DOCUMENT RESUME

ED 180 710	RC 011 741
TITLE	Indian Health. Hearing Before the Select Committee on Indian Affairs. United States Senate, Ninety-Sixth Congress. First Session on Indian Health.
INSTITUTION	Congress of the U.S., Washington, D.C. Senate Select Committee on Indian Affairs.
PUB DATE	2 Aug 79
NOTE	99p.: Not available in paper copy due tc small print size
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Agency Role: American Indian Culture: *American Indians: *Delivery Systems: Federal Aid: Federal Indian Relationship: Health Needs: *Health Services: Medical Care Evaluation: Preventive Medicine: Religious Agencies: *Self Determination: Tribes: *Trust Responsibility (Government): Veterinary Medicine
IDENTIFIERS	Congress 96th: *Indian Health Service: Senate Select Committee on Indian Affairs: *Traditional Medicine

ABSTRACT

The Senate Select Committee on Indian Affairs held its first session on Indian health on August 2, 1979, to consider the Indian Health Service (IHS) and to receive testimony from organizaticns concerned about the status of Indian health. The National Indian Health Board representatives discussed difficulties related to tribal efforts to achieve an equal partnership with IHS in health care delivery, administrative problems stemming from IHS's rapid growth, a new funding method based on a guaranteed benefits package, and the need for IHS to work with traditional medicine men. The representative of the Association of American Indian Physicians also stressed legitimizing traditional medicine and emphasized the importance of IHS's role as Trust agent for Indian health care. A panel of representatives from various religious groups read a statement of concerns about Indian health care. They recommended that the IHS eligibility status and reports of IHS malpractice be investigated, and that IHS should be sensitive to traditional beliefs. Finally, a representative of the Associaticn of American Veterinary Medical Colleges recommended the addition of veterinarians to IHS preventive medicine teams, perhaps to fulfill proposed public service requirements of veterinary students on scholarship. (SB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED180710

INDIAN HEALTH

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

INDIAN HEALTH

AUGUST 2, 1979
WASHINGTON, D.C.

Printed for the use of the Select Committee on Indian Affairs

NOV 1979
ERIC/CRESS
RECEIVED

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

50-308

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1979

RC 011741

SELECT COMMITTEE ON INDIAN AFFAIRS

JOHN MELCHER, Montana, *Chairman*

DANIEL K. INOUYE, Hawaii	WILLIAM S. COHEN, Maine
DENNIS DECONCINI, Arizona	MARK O. HATFIELD, Oregon

MAX I. RICHTMAN, *Assistant Chief Counsel*

ED178270

CONTENTS

STATEMENTS

Panel discussion:

Page
John Powless, deputy director, National Indian Health Board 2
Prepared statement 2
Dan Press, legal counsel, National Indian Health Board 2
Dr. Everett Rhoades, founding president and current board member, Association of American Indian Physicians 30
Prepared statement 30

Panel discussion:

Donald Reeves, legislative secretary, Friends Committee on National Legislation 48
Prepared statement 48
Jan Harmon, legislative assistant, Friends Committee on National Legislation 53
Rev. James West, National Council of Churches of Christ in the United States of America 54
Prepared statement 54
Rev. David R. Adair, program director, Oklahoma Indian Missionaries, United Methodist Church 68
Eugene Crawford, executive director, National Indian Lutheran Board 70
John Melcher, S.J., Saint Francis Mission, National Jesuit Office of Social Ministries 72
Gasper LoBiando, S.J., director, National Office of Jesuit Social Ministries 79
W. M. Decker, D.V.M., Washington representative, Association of American Veterinary Medical Colleges 82
Prepared statement 83
Resolution of the National Urban Indian Council 94

INDIAN HEALTH

THURSDAY, AUGUST 2, 1979

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 10:11 a.m., in room 5110, Dirksen Senate Office Building, Senator John Melcher (chairman of the committee) presiding.

Staff present: Gary N. Kimble, counsel; Max I. Richtman, assistant chief counsel; and Virginia Boylan, staff attorney.

Senator MELCHER. The committee will come to order.

This morning we are meeting to consider the Indian Health Service. This committee has primary jurisdiction in the Senate on Indian health programs. It is time we were holding this oversight hearing.

Although the committee planned in the last Congress to hold Indian health service oversight hearings to address problems in the administration of Indian health care, the committee did not schedule any of these hearings.

Since the beginning of this Congress, starting this year, the Select Committee on Indian Affairs has received many requests for Indian Health Service oversight hearings.

We intend to follow up this initial hearing here in Washington with probably three or four hearings in the field in various parts of the country. We have not scheduled any hearings at this time. However, we would like to have a committee hearing in at least California, some location in the Northwest or the upper Plains States, and one in the Southwest.

Senator Inouye has consented to conduct one of the hearings in California. Tentatively we think that will be in October.

Probably the other two hearings—or perhaps there will even be a fourth hearing after this in the field—will be held either in October or November.

The purpose of the hearing today is to receive testimony from a number of organizations who have expressed their concern with the status of Indian health and the role of the Indian Health Service in meeting Indian health needs. The committee hopes this testimony will pinpoint the major issues in the area of Indian health which should be addressed by this committee when it conducts oversight field hearings this fall.

As a result of these hearings, we hope to not only just talk about the problems, but we hope to have the problems identified in terms of what can be done to correct the administration of the IHS programs as well as in terms of how much money it will cost and where the money is needed.

Our first witnesses today will be a panel representing the National Indian Health Board.

Is Howard Tommie, the chairman, present?

[No response.]

I do not think he is present. However, John Powless, deputy director, and Dan Press, legal counsel, National Indian Health Board, I believe are present.

Please come forward.

John, are you going to be the spokesperson?

STATEMENT OF JOHN POWLESS, DEPUTY DIRECTOR, NATIONAL INDIAN HEALTH BOARD, AND DAN PRESS, LEGAL COUNSEL, NATIONAL INDIAN HEALTH BOARD

Mr. POWLESS. Yes, sir, for the time being.

Senator MELCHER. We have your testimony. You may present it in any way you see fit. Please proceed. If you want to make your statement part of the record and summarize it or if you want to read it into the record, do as you see fit.

Mr. POWLESS. We will submit it as part of the record and summarize the key points of our testimony.

Senator MELCHER. All right. Please proceed.

[Material follows:]

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD, AUGUST 2, 1979

The National Indian Health Board (NIHB) appreciates this opportunity to appear before this Committee to participate in these important oversight hearings on the Indian Health Service. We believe this is an appropriate and critical time for such hearings because it is a time both of excitement and concern in the Indian community in regard to the issues of Indian health. It is an exciting time because Indian tribes are beginning to exercise their self-determination and sovereignty in the area of health. Tribal projects in the area of health are blossoming both in the number and range of areas into which tribes are entering. The National Indian Health Board just completed its third annual health conference. An example of the breadth of concerns tribes now have in the area of health can be seen by examining the agenda (copy enclosed). The agenda covered everything from the tribal efforts to reestablish traditional medicine as an equal partner in the area of health to the problems of nuclear pollution on Indian reservations. We believe that when people talk about Indian health it no longer means just IHS, it means the total Indian health system—IHS plus those programs being administered by tribes.

However, the tribes' rapid growth in this area has created an equal need for additional resources and additional authorities and policies so they can fully exercise their authority in this area. Therefore, one focus of our testimony and one set of issues we hope the Committee will explore in its field hearings is on the gaps—both in terms of resources and government policies—that serve as roadblocks to the tribes' efforts to achieve equal partnership with IHS in the delivery of health care to their people. We think that the focus of Indian people is away from a single focus on IHS—both in terms of filling needs and for criticizing—and increasingly focusing inward to see how their own resources can contribute to the improved health of the Indian people.

Another focus of our testimony is on the Indian Health Service. IHS has grown very rapidly over the past ten years. Its budget has increased over fivefold and the areas over which it has responsibility has also increased quite rapidly, particularly its responsibilities to assist tribes achieve self-determination in the area of health. This rapid growth has created a number of problems within IHS that we believe should be another major focus of these hearings, looking at the constructive steps that the Congress and IHS can take to correct the problems that have arisen over the past few years. These include management weaknesses within IHS, problems in IHS' accountability to the Indian people, problems in its definition of the rights of Indian people vis-a-vis Indian Health Service, and problems in the areas of budgeting and staffing.

Some of the specific issues within these two categories are discussed below.

IHS MANAGEMENT AND ACCOUNTABILITY

One of the problems we have identified is a weakness in the management of Indian Health Service. It is often difficult getting decisions made below the level of the Director or determining who is responsible for particular decisions. We believe that the IHS management structure has not grown accordingly with its rapid growth in budget and responsibility and needs to be looked at closely for ways to strengthen it. We believe that many of the problems that will be raised during the field hearings can be traced to the weakness in IHS management.

One of the spinoffs of this management problem is the difficulty Indian tribes and Indian consumers have in holding IHS accountable. Historically, one of IHS' greatest strengths has been its flexibility and willingness to adapt to meet changing circumstances and efforts by tribes to develop in unique ways. However, the negative aspect of this is that it is very difficult for tribes and Indian consumers to determine what rights they have or to obtain relief when they believe IHS has violated their rights. This manifests itself in a number of ways. First, there is no adequate grievance procedure for Indian consumers who believe that they have been mistreated by IHS delivery staff such as doctors, nurses, etc. You probably will have, during your field hearings, many witnesses testifying about medical services they received from IHS which they believe were deficient in some way. Whether they are right or wrong, they have never had an adequate opportunity to get their grievances heard in a manner which assures them a fair hearing and one that leaves them satisfied that their problems have been properly considered and dealt with.

The same problem occurs at the policy level. IHS frequently says that Indian tribes, health boards, etc. can set the direction for Indian Health Service. However, when a Service Unit Director or an Area Director fails to act in accordance with a tribal request, it is very difficult for that tribe or board to get a satisfactory explanation of why its position was not followed, nor are there mechanisms to get the decision considered and perhaps reversed at a higher level. Clearly, IHS cannot delegate policy authority to tribes under existing authority. But if they do want tribes' advice and priorities, some mechanisms need to be put in place to make this more than an empty gesture on the part of the tribes whenever an IHS official decides, in his infinite wisdom, to ignore the tribes' recommendation.

We believe that many of the issues that will be raised during the field hearings will relate to these two specific points, the inability of individual consumers to obtain adequate responses to their grievances and the inability of Indian tribes and area health boards to obtain an adequate hearing when IHS takes positions that are in variance with those of the Indian tribe or board. We believe that dispute resolution mechanisms do exist that could resolve most of these problems in-house and obviate the need for Indians to take these problems to a level above IHS. We also believe it will eliminate much of the animosity that exists between Indian consumers, tribes, and the Indian Health Service.

A related issue involves the increasing effort of tribes to have a policy role in the development and administration of Indian Health Service programs. Tribes are now faced with two often unpalatable alternatives. Either they have simply an advisory role, as indicated above, subject to rejection by Indian Health Service if it disagrees, or they may contract the entire program, which requires them to take over enormous administrative burdens in addition to the policy control—administrative burdens which most tribes are not prepared to assume at this time. The Bureau of Indian Affairs Self-Determination Regulations contain a provision which allows tribes to set policy for Bureau programs without having to assume administrative responsibility for them. The provision, 272.27 of the BIA Self-Determination Grant Regulations, allows the tribe to plan or redesign any BIA program and the Bureau is, in turn, required to implement that plan so long as the tribe's plan meets general funding, staffing and administrative requirements within which the Bureau must act. We believe a similar provision should be adopted for the Indian Health Service so that tribes can exercise policy control even where they are not ready to contract the entire program.

Lastly, in the area of IHS-Indian accountability problems, we would like to raise problems that have arisen around 638 contracting. This continues to be a major source of friction between Indian tribes and boards and Indian Health Service. The problem is that in practice the contract negotiations rarely are the arm-length's negotiations between equals that was projected in the regulations. IHS contracting officers too often dictate the terms of the contract to Indian tribes and seek to impose upon them the contracting officer's own programmatic preferences, under the guise that they are required by federal procurement law even when no such law or regulation exists. We ask that the Committee examine closely the 638 contracting procedures and develop mechanisms that will enable tribes to be equal negotiating partners in these contract negotiations.

Looking at another aspect of management, we believe that the management problems IHS has experienced come, in part, from the awkward way in which its appropriations and its staffing needs are dealt with by HEW and by the Congress. We understand the need for position ceilings in order to hold down the growth of the federal government. At times there is also a need to put a freeze on government hiring. However, both of these governmental processes take a severe toll on Indian Health Service. Too often IHS will build a new health facility but not have the position slots to staff it and the facility goes unused until it can get OMB to request additional position slots from the Congress. Also a freeze in a federal grant program has no immediate impact. However, when a freeze is placed on Indian Health Service, it means that key medical positions such as nurses, lab technicians, etc. go unfilled which create immediate medical dangers for Indian people. Every time there is a freeze, Indian Health Service has to go begging to HEW or OMB for exemption from the freeze. Too often this is granted several months after the freeze was enacted, during which time Indian people's health has been endangered by the shortage of key medical staff. We therefore recommend that the Committee examine the possibility of removing the position ceiling requirement from the Indian Health Service. This has been tried with several other federal agencies and appears to have worked. The agencies are permitted to hire as many staff as they need and can afford within their budgets. We believe such an approach can also promote more efficient medicine in IHS since in some cases it may make more sense to hire two physician assistants than it does to hire a single physician. IHS should not be prohibited by the budget ceiling from using such innovative techniques.

THE GUARANTEED BENEFIT PACKAGE

We also request that for the future, the Committee adopt a new system for setting appropriations for the basic health care needs of Indians. Each year at appropriations time, hundreds of Indian leaders are forced to spend a great deal of time and money to come to Washington to beseech the Appropriations Committees to add a few more dollars to fill the most serious gaps in the budget request. We believe that it is inappropriate for the Indian Community and the Congress to spend so much time and effort each year arguing with the Administration over how much money is needed to provide very basic health care services—inpatient and outpatient—to Indian people. This Congress has already acknowledged the right of Indian people to basic health services and we do not understand why it is necessary for Indian leaders to come in year after year and argue for sufficient funding for inpatient care, outpatient care and contract health care. Funding for these basic items—which cover such procedures as obstetrics, surgery, treatment of gastroenteritis and diabetes, etc.—should be guaranteed and should not be open to debate or to the vagaries of the budget process. From the Congress' perspective, the time spent on testimony on appropriations for these basic care items detracts from the time needed to focus on the issues that do require close scrutiny, discussions, and policy decisions, such as the funding level and proper use of funds for such policy-related categories as manpower development, self-determination programs and IHS administration.

We, therefore, request that the Committee instruct the Administration to institute a guaranteed benefit package approach for the funding of the basic health care services provided by IHS. Under this approach IHS would determine the average cost of each of the procedures it provides, project the number of those procedures it expects to provide during the next fiscal year and then multiply to determine the total cost of providing all of the basic health care services over the next year. The Committee should require that the Administration submit this total figure as its budget request for the patient care, outpatient care and contract care line items in the IHS budget. This guaranteed benefit package approach is used by Medicare and Medicaid and by HMOs. We believe it must be adopted into the IHS appropriations system so that (1) there will no longer be any questions or debate about whether there is sufficient funding to provide Indians with the basic life and death kinds of services to which they should have a right, and (2) to enable the Congress, IHS, and the Indian community to focus their attention on those appropriations issues which involve major policy analysis and decisions.

TRUST RESPONSIBILITY

The oversight hearings should focus on the trust responsibility that the IHS has to Indian people. As a trustee the Indian Health Service must act in the best interest of its client, the Indian people.

The question of trusteeship raises other questions as to whether IHS is residual or primary provider of health care to Indian people. The Indian Health Service considers itself a residual provider. Thus while Indian people view IHS, legally and practically, as their primary provider, IHS has been forced to adopt this residual argument so that Indian people and IHS can tap the resources available in other health programs—Medicaid, Medicare, and other third party reimbursers. However, IHS' position that it is residual undercuts the legal rights of Indians and the legal responsibilities of IHS and poses unforeseen dangers for the future. NIHB supports IHS' effort to tap as many third party resources as possible, but we ask the Committee to explore legislative changes so that IHS can tap these resources without having to adopt a position that endangers Indian rights.

The field hearings should concentrate on the problems that Indian people face when they have to leave the reservation to obtain health care that cannot be provided on the reservation by the Indian Health Service.

CONTRACT HEALTH CARE REGULATIONS

The contract health care "on and near" regulations developed by the Indian Health Service do not reflect the wishes of the tribes for whom they were written. The regulations outline the criteria for which Indians will be eligible to have IHS pay for their health care services when the services are provided in a non-IHS facility.

The regulations stipulate that those Indians that live off the reservation must live in a county that adjoins the reservation to be eligible for contract care. Those that live two counties away will not be eligible for health care services from the IHS. Those Indians that move to an urban area are only eligible for contract health care for a specified number of days. Those that are students are eligible as long as they remain in school.

If a tribe wants to expand the boundaries of their contract care service areas beyond the one county limit, they must petition the Secretary of Health, Education, and Welfare, to have their boundaries redesignated. The process needs to be changed so that IHS and the tribes develop revised boundaries jointly, rather than framing it in the form of appeals to the Secretary. The participation of tribes in this process should not be minimized, but maximized.

PUBLIC LAW 94-437, INDIAN HEALTH CARE IMPROVEMENT ACT

Under Public Law 94-437 Indian tribes were able to develop comprehensive health plans. The plans have now been submitted to the Indian Health Service.

Indian people have raised serious questions about their health planning being a continuing process. Indian people are concerned that health plans will be disregarded and will accumulate dust on a shelf.

The hearing process should examine the health planning process as it is perceived by Indian people and by IHS. Health planning should be a continuing process, whereby health plans are updated annually.

A related issue to the 437 tribal specific planning process is problems tribes have had in dealing with Health Systems Agencies and related entities created by Public Law 93-641, the National Health Planning and Resource Development Act. These problems may be raised with the Committee during its field hearings. NIHB is pleased to report that through a joint effort by IHS, the Bureau of Health Planning, the Health Subcommittees of the Congress and NIHB, legislation and policies are now being developed to resolve these problems. Amendments to the Planning Act now before Conference Committee would require that HSAs treat Indian tribes in a manner that respects tribal sovereignty and self-determination and which promotes cooperative efforts based on that respect. A policy paper from HEW now in final stages of development establishes the same principle. NIHB will now be working with HEW to assist tribes and HSAs implement this principle in a constructive manner.

TRADITIONAL MEDICINE

Traditional medicine is overlooked in a lot of IHS hospitals, and in the comprehensive health care program of the Indian Health Service. However, traditional medicine is making a comeback and needs to be viewed as being equal to Western medicine. As one medicine man recently stated, "we have bilingual and bicultural, and now we need bi-health."

Over the years, traditional forms of medicine have been ignored, and have not been looked at as viable means to treating the health care needs of Indian people. However, it has never been put aside by the Indian people. Now that the concept of holistic medicine is becoming increasingly accepted by Western medicine, the value of traditional medicine, which seeks to maintain the physical and mental health of the Indian person, and sees physical and mental health as closely related, is obtaining increased respect and attention from Indian tribes and the medical community. Indian tribes are asking that traditional Indian medicine be recognized by IHS as an equal partner to Western medicine and is seeking resources to help perpetuate and expand the traditional medicine practice. The NIHB has been asked to recommend to the Congress that it establish mechanisms so that existing health resources can be used for this important tool in maintaining the total health of the Indian people.

There is a lot that can be learned from those who practice traditional medicine. Rather than rely on synthetic medicines that white men make, the Indian Health Service should be conducting research on the traditional healing practices of Indian medicine men, so that we can achieve a bi-medicine program that is considered an equal to Western medicine.

CHILD WELFARE

In the area of child abuse and neglect, the Indian Health Service has not developed a program that adequately clarifies the policy and procedures for dealing with this sensitive issue. Recently, IHS issued a statement that tribal courts would now be recognized as courts of competent jurisdiction. Prior to this recognition, IHS employees were reluctant or refused to work with the tribal courts in addressing the child abuse problems on Indian reservations. For example, there were questions on whether IHS was required to turn over records to the tribal court. There are still serious questions whether IHS will recognize the subpoena power of tribal courts.

With the passage of the Indian Child Welfare Act, tribal courts would be recognized as courts of competent jurisdiction, as would administrative bodies that the tribe sets up to deal with child welfare problems. If the Bureau of Indian Affairs recognizes administrative bodies as being equivalent to tribal courts, would IHS also recognize the administrative body of the tribe as a court of competent jurisdiction?

NUCLEAR POWER DEVELOPMENTS ON INDIAN RESERVATIONS

In the state of Washington there are four nuclear plants that are in operation and there are eight nuclear plants that are in the planning or construction stage. All 12 of these nuclear power plants will be in close proximity to Indian reservations. The health hazards associated with these nuclear plants has not been examined by the Indian Health Service. The Indian Health Service needs to develop an Indian radiological department that will study the impact that nuclear power plants have on the health conditions of the Indian community.

There are serious problems with uranium mining, on Navajo and other reservations, where the mining companies have left large deposits of mill tailings, which pose a serious health hazard. For example, recent statements by IHS physicians in one Service Unit indicated that out of 12 cases of lung cancer, 10 were from uranium miners. The piles of mill tailings at Red Rock, Arizona were never covered up by the uranium mining company, which is a serious health hazard on the reservation. Indian people living in the Red Rock community have tried to get the mill tailings buried, but without success. Indian people have become very frustrated in trying to clean up the mess, because no agency wants to assume responsibility. IHS will say it's a problem of the Department of Energy, the Bureau of Indian Affairs will not be responsible for cleaning up the mess even though they negotiated the leases with the uranium companies, and the uranium companies have since closed the mine and are no longer around. It is sad that no one government agency wants to assume responsibility for cleaning up this serious health hazard.

With the increased development of energy resources on Indian reservations, the Indian Health Service must be more concerned with the health conditions of the Indian people in these areas.

ALCOHOL AND DRUG ABUSE

Presently, Indian alcoholism programs have been in the process of transferring from the National Institute on Alcoholism and Alcohol Abuse to the Indian Health Service. To date, the Indian Health Service has not fully developed any policies and procedures governing an orderly transfer. As a result of the lack of sound policies, Indian alcoholism programs have experienced lapses in funding, and contract negotiations have been complex and confusing. The programs are told that they have the option of developing either a contract or grant mechanism. But all too often, the Indian alcoholism programs end up developing a contract relationship with the Indian Health Service. This contracting relationship with the Indian Health Service usually results in the development of an adversary relationship between the alcoholism program and the contracting officer of IHS.

The IHS has developed an Office of Alcoholism that is chiefly responsible for the transfer of alcoholism programs from NIAAA to IHS. IHS has also developed field coordinator positions. These field coordinators are responsible for assisting Indian alcoholism programs. The field coordinator positions are usually filled by people with little or no expertise in the alcoholism field. The field coordinators are also directly responsible to the IHS area directors. They are not accountable to the Office of Alcoholism and yet the Office of Alcoholism is chiefly responsible for alcoholism programs.

In order for alcoholism problems to be the number one priority of the IHS, IHS will have to develop strong policies and procedures, so that alcoholism programs don't get bogged down in political battles with IHS area office personnel.

In summary, we believe that the rapid growth of Indian Health Service has created some serious problems. We believe these issues will be raised frequently in the field hearings and we hope the Committee will explore them in depth. We also hope, however, that whatever solutions are developed do not throw the baby out with the bath. One of the great attributes of the IHS program over the years has been its flexibility in adapting to developing tribal areas and developing health needs of Indian people. We hope that the solutions developed do not tie IHS down so rigidly that it is unable to retain this very positive and productive flexibility. Nor should the criticisms of IHS detract from the very commendable job IHS has done in reducing morbidity and mortality of Indian people and in assisting Indian tribes develop their own health capability. The areas where we see problems are truly overshadowed by the areas in which IHS has admirably and successfully achieved its mission. We see these hearings as an instructive effort to take stock and to improve—and we hope all others participating in these hearings will approach them in the same positive manner.

THIRD NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE OF THE

NATIONAL INDIAN HEALTH BOARD
SPOKANE, WASHINGTON

PROGRAM

SUNDAY, JULY 22, 1979

2:00 p.m. - 9:00 p.m.	**Registration:** Sheraton-Spokane Hotel North 322 Spokane Falls Blvd.
12:00 noon - 8:00 p.m.	**Exhibitors into Exhibit Hall:** Spokane Convention Center West 334 Spokane Falls Blvd. (Southwest Quadrant)

MONDAY, JULY 23, 1979

8:00 a.m. - 5:00 p.m.	**Registration:** Spokane Convention Center (Lobby)

FIRST GENERAL ASSEMBLY
Spokane Convention Center (Opera House)

8:30 a.m.	**Call to Order:** Howard E. Tommie, Chairman National Indian Health Board
	Presentation of Colors: Northwest Tribes
	Invocation: Delbert Frank, Sr., Vice-Chairman Warm Springs Tribe
9:00 a.m.	**Welcoming Address:** Howard E. Tommie, Chairman National Indian Health Board
	Overview of Past NIHB National Conferences; Introduction of National Indian Health Board Members and Indian Health Service Area Directors
9:15 a.m.	**Welcome from the Host Tribes:** Mel Sampson, Chairman Northwest Portland Area Indian Health Board
9:30 a.m.	**Keynote Speaker:** Dr. Emery A. Johnson Assistant Surgeon General Director, Indian Health Service

10:00 a.m.	Overview of Legislative Program: Daniel Press, General Counsel National Indian Health Board
10:30 a.m.	Development of Indian Health Manpower William Wilson, Executive Director Association of American Indian Physicians
11:00 a.m.	RECESS
1:00 p.m. - 2:25 p.m.	LEGISLATION WORKSHOPS — SESSION I
Sheraton-Spokane Hotel Meeting Room/South B	National Health Insurance/National Health Planning and Resources Development Act of 1974 (P.L. 93-641) Facilitator: Howard Bad Hand, NIHB Program Analyst Moderator: Billy Kane, NIHB Representative, Phoenix Area
Spokane Convention Center Northwest Quadrant	Indian Health Manpower Development Facilitator: William Wilson, Executive Director, Association of American Indian Physicians Moderator: Marlene Haffner, M.D., Director, Navajo Area IHS
Sheraton-Spokane Hotel Ballroom Center	Tribal Specific Health Plans and the Implementation of Health Services and Centers Amendments of 1978 (P.L. 95-626) Facilitator: Jack Casebolt, Director, IHS Office of Program Planning Moderator: Lawrence Snake, NIHB Representative, Oklahoma Area
Sheraton-Spokane Hotel Ballroom/North	Contracts, Grants and Intergovernmental Personnel Assignments Facilitator: James Danielson, Director, IHS Office of Program Support Moderator: Elwood Saganey, NIHB Representative, Navajo Area

Sheraton-Spokane Hotel
Meeting Room/South A

Status of Area Indian Health Boards

Facilitator: Ethel Gonzales
NIHB Representative
Alaska Area

Co-Facilitator: Ronald A. Hodge,
Attorney

Moderator: John Belindo
NIHB Executive Director

Spokane Convention Center
Meeting Room A

Traditional Indian Medicine

Facilitator: Edward Tso, Director
Office of Native Healing Science
Navajo Health Authority

Moderator: Jack Jackson
Councilman
Navajo Tribe

Panel Members: Miller Nez, President
Navajo Medicine Men's Association

Ruth Roessel, Director
Rough Rock Demonstration School
Resource Center

Stanley Red Bird, Chairman
Rosebud Medicine Men & Assocs.

Spokane Convention Center
Meeting Rooms B & C

Legal Developments

Facilitator: Raymond Cross, Attorney
Native American Rights Fund
Boulder, Colorado

Co-Facilitator: Bruce Davies, Attorney
Native American Rights Fund
Boulder, Colorado

Moderator: John Davis, Director
IHS Oklahoma Area

Spokane Convention Center
Meeting Rooms E & F

Indian Provisions of the Food Stamp Act of 1977

Facilitator: Bob Price, Director
Commodity Food Program
Papago Tribe

Moderator: Timm Williams
NIHB Representative
California Area

Sheraton-Spokane Hotel
Meeting Room/South C

1980 Census

Facilitator: Marion Wolf, Program Analyst
U.S. Bureau of the Census

Moderator: Larry Lucas
Minority Program Specialist
U.S. Bureau of the Census

2:30 p.m. LEGISLATION WORKSHOPS — SESSION I WILL REPEAT IN LEGISLATION WORKSHOPS — SESSION II

4:00 p.m. - 5:00 p.m. Develop Workshop Reports

EVENING ENTERTAINMENT

6:30 p.m.
Grounds of the Sheraton—Spokane Hotel
Salmon Bake—Hosted by the Tribes of the Northwest

Spokane Convention Center
Pow-Wow—Hosted by the Northwest Portland Area Indian Health Board

TUESDAY, JULY 24, 1979

SECOND GENERAL ASSEMBLY
Spokane Convention Center
(Opera House)

8:30 a.m.

Call to Order: Ethel Gonzales, Vice-Chairman
National Indian Health Board

Invocation: Agnes Nichols
Aleut Tribe
Member, Alaska
Native Health Board

Welcoming Address: Ethel Gonzales, Vice-Chairman
National Indian Health Board

9:00 a.m.

Highlights of Legislative Workshops and Presentation of Reports:
Daniel Press, General Counsel
National Indian Health Board

9:45 a.m. - 10:15 a.m.

Overview of Human Services Program:
James Smith, Director
IHS Billings Area

10:30 a.m. - 12:30 p.m. HUMAN SERVICES WORKSHOPS — SESSION I

Spokane Convention Center
Northwest Quadrant
Alcohol Abuse

Facilitator: Bud Mason, Director
IHS Office of Alcoholism

Co-Facilitator: Dr. James Andre
Physician Advisor
IHS Office of Alcoholism

Moderator: Virgil Gunn, Chairman
Health, Education and Welfare Committee
Colville Tribe
Nespelem, Washington

Sheraton-Spokane Hotel
Meeting Room/South C

Substance Abuse

Facilitator: Albert Pooley, President
American Indian Resource Org.
Tempe, Arizona

Moderator: Jim Meredith, Director
IHS USET Area

Sheraton-Spokane Hotel
Ballroom/Center

Emergency Medical Services

Facilitator: John Emelio, Director
IHS Emergency Medical Services Program

Moderator: Daniel Foote
NIHB Representative
Billings Area

Sheraton-Spokane Hotel
Meeting Room/South A

Indian Elderly

Facilitator: George Effman, Chairman
National Indian Council on Aging

Moderator: C. S. Stitt, D.D.S.
Director, IHS Portland Area

Spokane Convention Center
Meeting Room A

Patient Rights

Facilitator: Elliott Booth
Tribal Health Coordinator
Colorado River Tribes

Co-Facilitator: Adelma Pedro
Patient Representative
Phoenix Service Unit
Indian Health Board, Inc.

Moderator: John Buckanaga, Director
IHS Bemidji Area

Spokane Convention Center
Meeting Rooms B, C, & D

Title XX of the Social Security Act

Facilitator: Don Milligan, Chief
Office of Indian Affairs
Department of Social & Health Services
Olympia, Washington

Moderator: Dr. Edd Brown
Office of Intergovernmental Operations
Arizona Department of Economic Security

Panel Members: To Be Announced

Sheraton-Spokane Hotel
Meeting Room/South B

Indian Child Welfare Act

Facilitator: National Congress of American Indians

John Ghostbear, Attorney
Harris, Ghostbear and Assoc.
Tulsa, Oklahoma

Richard Hughes, Attorney
Luebben, Hughes & Kelly
Albuquerque, New Mexico

Moderator: Linda Lejero
NIHB Representative
Tucson Area

Sheraton-Spokane Hotel
Ballroom/North

Urban Indian Health Care

Facilitator: Luana Reyes, Chairperson
American Indian Health Care Association

Moderator: Gerald Ivey, Director
Alaska Native Health Service

Spokane Convention Center
Meeting Rooms E & F

Recommended Changes And/Or Additions To Improve P.L. 94-437

Facilitator: Robert Birch, D.D.S.
IHS P.L. 94-437 Project Manager

Moderator: Ken Black, Executive Director
National Tribal Chairmen's Assoc.

12:30 p.m. RECESS

2:00 p.m. - 4:00 p.m. HUMAN SERVICES WORKSHOPS — SESSION I WILL REPEAT IN HUMAN SERVICES WORKSHOPS — SESSION II

4:00 p.m. - 5:00 p.m. Develop Workshop Reports

EVENING ENTERTAINMENT

6:00 p.m. Cash Bar (Spokane Convention Center/Patio)

7:00 p.m. **Banquet (Spokane Convention Center)**

Master of Ceremonies: Joseph de la Cruz
Chairman, Quinault Tribe

Keynote Speaker: Dr. Everett R. Rhoades, M.D.
Professor of Medicine and Microbiology
University of Oklahoma
Chief, Infectious Diseases
Veterans Administration Hospital
Oklahoma City, Oklahoma

9:00 p.m. Modern Dance
Sheraton-Spokane Hotel Ballroom

WEDNESDAY, JULY 25, 1979

THIRD GENERAL ASSEMBLY
Spokane Convention Center
(Opera House)

8:30 a.m. Call to Order: Donald LaPointe
Secretary/Treasurer
National Indian Health Board

Invocation: Lionel Boyer, Vice Chairman
Shoshone-Bannock Tribe
Member, Northwest Portland Area
Indian Health Board

Welcoming Address: Donald LaPointe
Secretary/Treasurer
National Indian Health Board

9:00 a.m. Highlights of Human Services Workshops
Presentation of Reports:
James Smith, Director
IHS Billings Area

9:45 a.m. - 10:15 a.m. Overview of Mental Health Programs:
H. C. Townsley, M.D.
Director, IHS Mental Health Program
Albuquerque, New Mexico

10:30 a.m. - 12:30 p.m. MENTAL HEALTH WORKSHOPS — SESSION I

Sheraton-Spokane Hotel
Ballroom/North

Mentally and Physically Handicapped

Facilitator: Theodore Marrs, M.D.
Director, IHS Indian Children's Program

Co-Facilitator: Albert Hiat, Ph.D.
Project Director
IHS, Indian Children's Program

Moderator: George E. Blue Spruce, Jr., D.D.S.
Director, IHS Phoenix Area

Panel Members: Manny Moran, M.S.
Special Assistant to Director
IHS Indian Children's Program

Roland Johnson
Administrator
IHS Indian Children's Program

Betty Bitsue
Psychiatric Social Worker
PHS Indian Health Center

Joseph Pugliese
MSW Social Worker
IHS Indian Children's Program

Sheraton-Spokane Hotel
Ballroom/Center

Mental Health

Facilitator: Dr. Jerry Meketon, Ph.D.
Chief, Quality Assurance and Training
IHS Office of Mental Health Programs
Albuquerque, New Mexico

Co-Facilitator: Robert Cary, M.D.
Director, Regional Inpatient
Psychiatric Unit
IHS Office of Mental Health Programs
Rapid City, South Dakota

Moderator: Roger Jim, Councilman
Yakima Tribe
Toppenish, Washington

Sheraton-Spokane Hotel
Meeting Room/South B & C

Child Abuse and Neglect

Facilitator: C. H. McCracken, M.D.
Maternal & Child Health Consultant
Billings Area IHS

Moderator: George Platero
NIHB Representative
Albuquerque Area

Sheraton-Spokane Hotel
Ballroom/North

Battered Spouses

Facilitator: Mel Sampson
NIHB Representative
Portland Area

Moderator: Rupert Clark, M.D.
Acting Director, Aberdeen Area IHS

Panel Members: Walter Farrow
IHS Social Worker
Yakima Service Unit

Naomi Shephard
Community Worker
Department of Social and Health Services
Washington State

Patty Nagle
Past Director
Dawson House Shelter

Tallulah Tinkhan
Mental Health Worker
Yakima Service Unit

Virginia June
Psychiatric Nurses Consultant
Navajo Area IHS Office

Sheraton-Spokane Hotel
Meeting Room/South A

Nuclear Development on Indian Reservations

Facilitator: Andy Fernando
Nuclear Study Project Director
Skagit System Cooperative
LaConner, Washington

Moderator: Violet Hillaire, Chairperson
Northwest Washington Service Unit Board

12:30 p.m. RECESS

2:00 p.m. - 4:00 p.m. MENTAL HEALTH WORKSHOPS — SESSION I WILL REPEAT IN MENTAL HEALTH WORKSHOPS — SESSION II

4:00 p.m. - 5:00 p.m. Develop Workshop Reports

THURSDAY, JULY 26, 1979

FOURTH GENERAL ASSEMBLY

Spokane Convention Center (Opera House)

8:30 a.m.

Call to Order: Howard E. Tommie, Chairman
National Indian Health Board

Invocation: Emma Farrow
Umatilla Tribe, Member
Northwest Portland Area
Indian Health Board

9:00 a.m.	Highlights of Mental Health Workshops and Presentation of Reports: H. C. Townsley, M.D. Director, IHS Mental Health Program Albuquerque, New Mexico
9:30 a.m.	Report from Resolutions Committee: Donald LaPointe, Chairman NIHB Resolutions Committee
10:30 a.m.	Conference Wrap-Up and Closing Remarks: Howard E. Tommie, Chairman National Indian Health Board

ADJOURNMENT OF THE THIRD NATIONAL
INDIAN/ALASKA NATIVE HEALTH CONFERENCE

Mr. Powless. First of all, we would like to thank the Senator for this opportunity to present our testimony before this committee and to raise to you some of the key issues that we see in the field of Indian health.

The National Indian Health Board is a national Indian organization working with tribes throughout the United States in the areas of health. We have a broad constituency in just about all of the IHS areas, who in turn vote for representatives to sit on our national board. These representatives come from the local areas. Therefore, our board is always aware of problems that the people at the local level are facing.

At this time we would like to touch on areas such as self-determination, sovereignty, and the Indian people becoming an equal partner with the Indian Health Service in development of an overall health program for Indian people. We would like to touch on issues such as traditional medicine and nuclear power development on Indian reservations. Also we would like to discuss to some extent the rapid growth that tribes are experiencing in terms of wanting to assume more control over the health programs on their reservations.

At this time I would like to turn the testimony over to Mr. Dan Press, our legal counsel, to discuss the management problems as well as to discuss to some extent a guaranteed benefit package for American Indians.

Senator **Melcher.** Please proceed.

Mr. Press. Mr. Chairman, Howard Tommie, the chairman of the National Indian Health Board, was hoping to be here today. However, he had a last-minute emergency at his tribe. I am sure you are aware of the kinds of problems that pop up. He expresses his deep regret that he could not be here. He asked me to fill in for him this morning.

When we view the Indian health system, we view it as being two parts. It is not solely the Indian Health Service, although that clearly is an important part of it. Over the past few years tribes have assumed a much larger role in the delivery of health programs to their people. We now talk about the Indian health system which is a combination of both tribal and Federal programs delivered on Indian reservations.

The range of programs tribes are getting into was highlighted at our last conference. We regret that the Senator could not be there. The issues covered everything from the revival of traditional Indian medicine to the problems of nuclear pollution on reservations, from the very old to the very new.

Our testimony today will focus on the two areas of things that are needed by the Indian tribes to help them expand their control over the health programs on the reservations and changes that we believe are needed in the Indian Health Service itself so that we can better carry out its mission.

Looking at Indian Health Service initially, one issue we wish to raise is that we think Indian Health Service has grown very rapidly over the past 10 years. Its budget has increased by over fivefold. We have a feeling that its management capabilities have not grown accordingly. It has taken on many new responsibilities. There have been several major pieces of legislation and a lot more money. Indian people at times feel that the program is somewhat rudderless—that there needs to be stronger management, particularly below the level of the executive director, who we do believe is a very strong manager but the system under him seems to leave a lot of gaps. We hope that is one issue the committee will consider during its hearings.

A second major problem we perceive with the Indian Health Service is problems Indian people and Indian tribes have holding the Indian Health Service accountable. We believe this occurs at two levels.

First, Indian patients have individual grievances against the Indian Health Service. I think you will hear throughout the field hearings lots of specific horror stories of people coming into an Indian health facility and receiving treatment that they felt was not adequate.

It is our feeling that some of these problems are truly serious problems while others may not be. What is lacking in the Indian Health Service is an adequate grievance mechanism for patients so that they can have their problems heard and resolved properly. Because problems do not get a proper hearing, it builds up a tremendous amount of resentment which interferes with the physician-patient relationship and really undercuts the development process on reservations.

One of the things we ask you to look into is the development of effective dispute resolution mechanisms to which Indian patients can turn so that they do not have to come to the Congress, to the Secretary of HEW, or to others to get their problems resolved.

Another accountability problem is the problem Indian tribes have with the Indian Health Service. They very often feel that the buck does not stop anywhere, but goes round and round. The Indian Health Service will ask for tribal advice. They say, "You are really running the Indian Health Service. Please tell us your priorities and we will follow through on them." However, tribes find too often that IHS does not necessarily follow their priorities. An area director or service unit director may go off on his own. When tribes seek to get an explanation of why this happened or to find some way to challenge it, there is no way to get a handle on it.

Senator **Melcher**. Now, wait a minute. I would like to interrupt here if you do not mind.

You are going to have to be a bit more explicit than that before I can understand what you are saying. When you say a tribe does not think they are following the right kind of policy, what kind of policy are you talking about?

Mr. **Press**. For example, an area health board or an Indian tribe will say that the No. 1 priority of Indian health moneys should be alcoholism, and that whatever free resources there are in the Indian Health Service should be focused on alcoholism. That is their No. 1 health priority. Yet they find that when the service unit or the area director come down to allocating those resources, alcoholism is not given first priority, and few resources are allocated to it.

Therefore, they feel they go to great efforts to poll their people to establish priorities, and then the Indian Health Service does not always follow their priorities when it develops plans and allocates resources.

Senator **Melcher**. Do you mean a tribal council votes and says that, "Our No. 1 health problem is alcoholism"?

Mr. **Press**. Yes, sir.

Senator **Melcher**. That has happened?

Mr. **Press**. Yes, sir.

Senator MELCHER. Which tribal council was that?

Mr. PRESS. For example, the Billings area health board——

Senator MELCHER. The Billings area health board may or may not be representative of individual tribes' judgment on this. That is why I am asking these questions. I think you have to start with what the tribes say and not what is said by a group of people who are meeting as a health board representing 8, 9, or 12 tribes in an area.

Mr. PRESS. The eight tribes in Montana.

Senator MELCHER. Are they only Montana tribes? The area office covers more than Montana tribes?

Mr. PRESS. The Wind River Reservation is the only other area covered by the Billings area office. They have opted not to participate in the Montana area health board.

Senator MELCHER. I see.

I want to know specifically what the tribes find is wrong with the delivery of health care to individual tribes. If alcoholism is voted to be the No. 1 problem by the Northern Cheyenne, the Crow, the Fort Peck, and it is not being taken care of, I want to know that. However, I just do not want to have a group of people who are purportedly representing those tribes saying this is our No. 1 problem and it is not being met.

Can you vouch that that group really is speaking for the individual tribes?

Mr. PRESS. Yes, sir. It is my understanding the Billings area health board has a resolution from each of the tribes in the area indicating that they support the health board and that their representatives are authorized to speak on behalf of the health board.

Senator MELCHER. That is not good enough, because all too often, while a health board may be authorized to speak for a tribe, it really is not zeroing in on what the tribe believes is a major concern. This has to be more than just a group of people meeting purportedly representing the tribes. While that is a good starting point, it has to be supported by the tribes then saying, "Indeed, this is exactly what we want."

I can agree that alcoholism is a major health problem for several tribes of Montana. However, I am not sure that individual tribes have identified that is their No. 1 priority.

Mr. PRESS. I really do not want to purport to speak for individual tribes. When you have your field hearings, I think they will be able to raise these issues themselves. I prefer for them to raise them.

What the National Indian Health Board hears is periodically from tribes concerned that their priorities are not being complied with by the Indian Health Service.

Senator MELCHER. Do the tribes look at sources of funding for alcoholism treatment other than the Indian Health Service?

Mr. PRESS. Yes, sir.

Senator MELCHER. With any success?

Mr. PRESS. They do receive funding from the NIAAA, the National Institute of Alcoholism and Alcohol Abuse. Gradually those programs are being transferred back to the Indian Health Service because of problems.

Senator MELCHER. Is transferring those funds back into IHS the best procedure?

Mr. PRESS. That was the determination of the Indian community; yes, sir. They are the ones who advocated that procedure.

Senator **Melcher**. OK. Please proceed.

Mr. **Press**. Another issue that we wish to raise regards the appropriations process. I think we all agree there is a need for more money, but we also would like to talk about changes in the budgeting system. Those of us who come back year after year to testify before the Appropriations Committee, find it a very disheartening process. Hundreds of Indian leaders come back. They have 2 or 3 minutes to express their concerns. We feel there has to be a better process.

One issue we think has been taken care of. That is the bed methodology hospital priority list, which now sets a professional system for determining which hospital is a priority rather than having it based on other considerations.

Senator **Melcher**. Rather than what?

Mr. **Press**. In the past there was no clear way to know why a particular hospital was funded and another was not. Now there is a professional system for determining which reservation needs the hospital the most.

Senator **Melcher**. Does it work?

Mr. **Press**. Well, this is the first year it has been tried. Therefore, we really cannot tell you.

Senator **Melcher**. In this appropriations process I feel that it is true that Indian leaders come back here and go before the Appropriations Committee and have their minute, 2 minutes, 3 minutes, or whatever.

I am not going to try to defend the Appropriations Committee. I do not serve on it and never have served on the Appropriations Committee. I am not quite like Lee Metcalf. Lee Metcalf used to say, "I wouldn't serve on that committee if they made me chairman." I have not gone that far yet, but I never want to serve on the Appropriations Committee because it demands a long, tedious struggle through a hearing process with very, very short presentations.

As a matter of fact. Indian leaders probably receive better treatment from that committee as far as getting in to see them and actually presenting some testimony than do most other people throughout the United States. However, the Appropriations Committee has such limited time to reflect on testimony it receives while receiving billions of dollars worth of appropriation's requests that I do not think the Indian presentations are very satisfactory.

I think the authorizing committees which have more time to consider the individual problems must play a greater role in guiding what is finally done by the Appropriations Committee.

I have never served on an authorizing committee but that I felt we should supply the guidance to the appropriations process. We have more time as an authorizing committee to examine what should be in the appropriation bill for the Indian Health Service and other programs that are Indian-related and over which we have jurisdiction. We should take more responsibility in making sure the Appropriations Committee lives up to what we recommend as the adequate level of appropriations.

Of course, you will find that the Appropriations Committee cannot conduct field hearings throughout the United States or a hearing such as this on this specific problem. However, on the basis of our hearing record we expect to make reasonable recommendations for these programs. If our recommendations are not followed through by the Budget Committee and the Appropriations Committee, we want them to tell us why not. We might have a little greater success with that.

I do not want to discourage anybody from going before the Appropriations Committee in their process. However, I realize how tight their time schedules are and how often nothing is done about it. You come back, make your testimony, spend a lot of money to do that, and then find out you do not get anything out of it anyway. Maybe you have to wait 5 more years for your hospital to be considered for your tribe, or maybe 10 years, or maybe it is never considered. That is unsatisfactory. It is a waste of money as far as the tribes are concerned if they really do not get some results in that time frame.

I hope we can develop a system here where we make some strong recommendations to the Appropriations Committee and they either follow them or explain why they do not.

Mr. Press. Senator, we agree with you fully. In fact, we would like to recommend two approaches that may help you improve the appropriations process. One is the guaranteed benefit package approach for budgeting for basic in-patient and out-patient care. The other is the removal of the position ceiling and the exemption of Indian Health Service from any position freezes.

One of the reasons tribal leaders have to come back is to ask for additional money for basic in-patient and out-patient care, either contract care or direct care provided by Indian Health Service. The reason for this is that there is no relationship between the IHS budget and the actual number of procedures IHS has to deliver in the cost.

Medicare and Medicaid and most other Federal programs all are based on prospective budget. They say, "We are going to have 100 appendectomies. Each one of those costs $500. One hundred times $500 is the budget we provide for appendectomies."

The Indian Health Service has never been given the opportunity to budget that way. Instead it is a historical budget. Therefore, Indian leaders have to come back here and ask the Appropriations Committees to add money for basic lifesaving procedures. We believe that should never be an issue of debate anymore in front of the Appropriations Committees. That should be a guaranteed benefit package. Discussions between the Indian leaders and the Appropriations Committees should be on more policy-oriented issues of tribal development and other discretionary areas. There should be a guaranteed benefit package for basic services.

Another reason tribal leaders have to come back is they will get a new hospital or other facility and IHS is unable to staff it because the position ceiling does not give them the number of staff slots. Therefore, there are very expensive facilities underutilized or totally unused because IHS does not have position slots to fill them.

The Federal Government has been experimenting with the removal of position ceilings and letting an agency hire as many people as it can within its budget. We think this particularly appropriate in the Indian Health Service because in certain cases it may be more beneficial to hire two physician assistants than to hire a physician. You may get more for your money. However, a position ceiling keeps IHS from using these efficient methods.

The second change we would like to see is the removal of the position ceiling and a guarantee that IHS will never again be caught up by a freeze. Every time you freeze hiring in the Indian Health Service along with the rest of the Government, you take away emergency room nurses, you take away lab technicians, and you take away people whose absence can cause the death of Indian people.

Therefore, we ask that those two changes be made in the appropriations process. We think this is one way the authorization committee can provide better guidance to the Appropriations Committee and control some of the problems that have arisen.

I would now like to turn the microphone back to John Powless, who will talk about some of the other problems we would like to address.

Mr. POWLESS. The first area that we would like to touch on is the area of trust responsibility and the problems that arise in regard to the IHS being a trustee for Indian people.

The question of trustee has arisen lately in terms of whether IHS is a residual provider or a primary provider of health care. Usually IHS has had to perceive itself as a residual provider so that they could tap into other resources such as medicare and medicaid and other third party reimbursers.

However, we also are concerned about the legal rights of Indian people and the legal responsibilities of the Indian Health Service to continue to advocate for the sovereignty of Indian tribes so that their sovereignty is not watered down by having to go to other agencies to get funds to provide various types of health care on Indian reservations.

Just to give you a quick example, a lot of times in the area of mental health or even drug abuse in order for tribes to get funds to address that area where IHS does not have sufficient funding, a tribe would have to go to a State agency to get those funds, rather than having those funds coming directly to the tribe. We feel that IHS has a trust responsibility to advocate for the sovereignty of the tribe so that these funds do come directly to the tribe, rather than having to go to a State government to get their share of the funding.

We feel that the field hearings should concentrate on the problems that the Indian people face in this area. Questions of trust responsibility should be raised, how IHS perceives it and how the Indian people themselves perceive it.

The other area we would like to go into is dealing with contract health care regulations. Regulations have been developed by the Indian Health Service, entitled "on and near" regulations, which state in order for an Indian person to be eligible for contract health care he would have to be living in a county that adjoins the reservation. Therefore, it is conceivable if an Indian person were two counties away from the reservation he would not be eligible for contract health care. That might present a serious problem if a tribe does not have adequate health care facilities, or the IHS does not have adequate health care facilities and people have to rely on other doctors in communities outlying the reservation to get health care.

We feel that the tribes should be more directly involved in the designation of who is going to be eligible and who is not going to be eligible. The tribes have not been a part of this process. If the Indian tribes want to challenge any boundary designations that the IHS has established, then they would have to petition that boundary designation to the Secretary of HEW. Rather than get bogged down in an adversary relationship and a costly petition or administrative ruling process, we feel that the Indian tribes should be included as part of this process. It should be a joint partnership between the tribes and the Indian Health Service in trying to take care of the health care needs of as many people as possible.

The other area that needs attention in these hearings is dealing with Public Law 94-437, the Indian Health Care Improvement Act. The tribes have been working on health plans this past year. Most of the tribes have plans. Others have relied on IHS to do the health planning for them because of lack of expertise in their community to conduct a health planning program.

One of the concerns that has come to the attention of the National Indian Health Board is that the Indian Health Service perceives its health planning process as only a one-shot program. The Indian people have some serious questions about it being an ongoing program where the health plans would be updated from one year to the next.

There is some concern about these plans. Now that they are done, will they just be put on a shelf and then only come off the shelf when the appropriations hearings come up? To what extent will these health plans be followed in establishing policies for various areas? There are some serious questions about the viability of these health plans. The Indian people would like to have these become an annual process where they are continually updated.

Getting into the area of traditional medicine, we recently had a medicine man at our conference talk about the development of bilingual programs and bicultural programs. He brought up the new concept of having bihealth programs where we start to look at the various traditional forms of medicine and try to bring that up to a level where it is equal with Western medicine.

There are a lot of various types of traditional medicines that have been used in the past but have been neglected to a large extent in treating Indian people both for physical and mental health needs. By using the techniques and the medicine that the traditional medicine men are knowledgeable about, we feel that this might be a way to cut down on some of the direct health care costs with which IHS is presently faced.

We could use traditional medicine as a means to develop a strong prevention program on Indian reservations, where we take into account the various types of traditional forms of medicine or practices and try to treat both the physical and mental problems of Indian people before they come to the IHS facility. Rather than trying to have more moneys for more doctors and for more hospitals, there should be a stronger focus on reviving these traditional forms of medicine and incorporating them into the comprehensive health care program of the Indian Health Service.

With regard to the Indian Child Welfare Act which was recently signed by the President, the act indicates that tribal courts would be recognized as courts of competent jurisdiction. Also, administrative bodies would be recognized as tribal courts for purposes of the act.

Recently the Indian Health Service passed a ruling stating that tribal courts would now be considered courts of competent jurisdiction for child welfare cases, more particularly for child abuse and neglect cases.

Where these cases come to the attention of a doctor, there have been problems in the past of whether the doctor should give records that he has on a particular patient to a tribal court so that action can be commenced. A lot of physicians are reluctant to go into a tribal court and give them the records that they need.

Even in spite of tribal courts being recognized as courts of competent jurisdiction, there are still problems with the implementation of that—whether IHS area offices will recognize the subpoena power of a tribal court. Those things need to be looked at and the problems associated with them, so that we can begin to use the Indian Child Welfare Act to address a lot of these problems and have these problems addressed by the tribal courts on the reservations. These problems should not go into the non-Indian community to try to deal with these problems.

In our Third Annual Conference, which just took place, we had a workshop dealing with nuclear power developments on Indian reservations. This was the first one we have had. We have never looked into this very seriously as an organization. However, we are beginning to look at it. We have had problems come to our attention that need to be investigated.

I recently had a phone call from a lady in Minnesota. She was talking to me about a place called Prairie Island where there is a nuclear powerplant that is located next to Indian lands. These are Indian lands that are occupied by the Stantee Sioux people. It is about 30 miles south of Minneapolis. She was indicating to me that there are problems with deformed births because of these nuclear powerplants. There are problems with stillborn births amongst our Indian women.

We are going to develop a program whereby we begin to look into this and start to document these accusations and bring these things to the attention of the public, and in particular the Indian community.

There have been problems with uranium mining companies that come onto reservations and extract these large uranium deposits off of Indian reservations. Once they are completed, they usually leave piles of mill tailings which are still radioactive. When it rains, the runoff from these mill tailings can become a health hazard in the Indian community.

For example, there is a place called Red Rock, Ariz. According to an IHS physician there, they have had 12 cases of lung cancer in their service unit. Of those 12 cases, 10 of those cases were attributable to uranium miners. The IHS physicians in that area are very much alarmed about the high incidence of lung cancer amongst Indian people who are working in these mines.

There have been stories printed about children who get sores from the water that runs off of these mill tailings. There have been problems with sheep that drink the water and then the sheep that are eaten by the Indian people could be the carrier for some of these diseases that are attributable to the mill tailings.

Indian people have tried to get these deposits covered up or buried. They run into problems of buck-passing as to who is responsible for cleaning up this mess. Is it the Bureau of Indian Affairs that originally negotiated the leases? Is it the company that did the mining which has since left? Is it the Department of Energy or is it the Indian Health Service?

Senator **Melcher.** John, you will have to remember that I do not want generalities. You have cited the Navajo reservation. If you know of other reservations that have milltailings from uranium mining on them, tell us. Do not generalize.

Mr. **Powless.** OK. In southern Colorado around Ignacio and Towaco Indian Reservations, there are reports of milltailings being in those communities that affect Indians.

Recently a person, whose name is Andy Fernando, conducted our nuclear development workshop at our conference. He works with the upper Skagit tribes in central Washington. There are proposals to build nuclear powerplants——

Senator **Melcher.** I want to separate these issues. First of all, I want to know about problems involving uranium milltailings. You have identified Red Rock, Ariz. Is that right?

Mr. **Powless.** Red Rock and southern Colorado. Those are the only ones of which we are aware at this time.

Senator **Melcher.** Both of those tribes can approach the Department of Energy. I do serve on the Energy Committee. There is a Federal program for cleanup of nuclear waste and materials. Both of those tribes are capable of requesting such assistance. If they have not done that, it is their own fault. Please communicate with them to do so.

I would be amazed if the Navajos have not approached the Department of Energy. If they have had some problem, they can tell me.

You have to be specific on these things. Milltailings are extremely dangerous. If they have not been properly cared for, we will make sure they are. That is a Federal responsibility whether it occurs on an Indian reservation or anywhere. We are serving the American people in the Senate Energy Committee.

Anybody who has any problem with milltailings and anybody who has any problem with radioactive materials at or near or in any way connected with uranium mining should approach the Department of Energy. If they do not receive a response, they should let me know. I will be glad to make contact with the Department of Energy to make sure there is a response.

Mr. **Powless.** I have not been to Red Rock but I have read about it. Therefore, that is the one with which I am mainly familiar.

Senator **Melcher.** Is that part of the Navajo Nation?

Mr. **Powless.** Yes. I would have to plead ignorance on any other types of milltailing problems on other Indian reservations.

One of the recommendations that came out of one of our workshops on nuclear power failure was development of the Indian Radiological Department within IHS so that there can begin to be some research conducted to address this area in order to see what types of problems actually are existing and how these nuclear powerplants are being developed and will have an impact on the Indian community.

I recently was given some statistics that there are four powerplants that presently are operating in the State of Washington, which are close to Indian reservations. There are eight in the planning stage or in the construction stage which are also close to Indian reservations.

Therefore, there is a need to begin to look at the impact these powerplants possibly could have on Indian reservations.

Senator **Melcher**. Well, they have an impact on everybody. There are a lot of people near those plants. There is a question of national concern about what we are going to do to safeguard the plants' operations. I do not think that is unique to the Indian Health Service at all. It is a very broad problem. It is a matter of public policy that affects all people.

I do not want to discourage you from pursuing it with the Indian Health Service, but I do not think it is something that will be separated out for the Indian Health Service.

Mr. **Powless**. I will continue on to the next area of concern, which is the alcohol and drug abuse program within the Indian Health Service.

As we have already stated, there have been programs transferred from the National Institute of Alcoholism and Alcohol Abuse to the Indian Health Service. Some of the problems that have come to our attention in that area deal with development of policies and procedures that would assist in governing an orderly transfer of these programs to the Indian Health Service.

As a result of some of the policies or lack of policies, there have been lapses in funding for some of the alcoholism programs. There have been problems with contract negotiations with contracting officers, and Indian people not really understanding or being made knowledgeable about how the contracting negotiations take place prior to the transfer of these programs.

There are problems with regard to who is directly in charge of the alcoholism effort within the Indian Health Service. Is it going to be the Office of Alcoholism that has been developed, or is it going to be the area directors?

A problem that presently exists deals with the field coordinator positions within the area officers. These field coordinator positions are responsible to deal directly with the alcoholism programs in the field. A question arises as to whom the field coordinators are accountable. From whom do they take direction—the area director or the Office of Alcoholism?

The answer that we received was that the field coordinators are accountable to the area director. Therefore, if there are policies that are being implemented at the central Office of Alcoholism, there are problems with the implementation of those policies.

We feel there needs to be very strong policies and procedures developed so that there is an orderly transfer of these programs so that the alcoholism problem can be addressed as the No. 1 priority of the Indian Health Service.

That about concludes our testimony, Senator. We would like to thank the committee for this opportunity to bring some of these issues to your attention. We look forward to the field hearings and the opportunity to be more specific with regard to the problems that presently exist within the Indian Health Service.

We do not want to get into a situation where we are throwing the baby out with the bath because of our criticisms. We want our criticisms to be constructive in terms of strengthening the Indian Health Service and in terms of strengthening the comprehensive health care programs on Indian reservations. We want to try to maximize the participation of Indian people in delivery of health care services on Indian reservations.

Thank you very much.

Senator **Melcher**. I think a basic decision which we always have to make is whether we want to concentrate the amount of money that is going to be spent through the Indian Health Service on the reservations, or whether we want to try to reach out where the Indians are living off the reservations. In my experience, the Montana tribes have wanted these funds concentrated on the reservation for fear that spreading out these funds too much would make it impossible to operate a good health care service on the reservation.

I do not know how far off the reservation we can go—perhaps a limitation of a county or two counties nearby. If we broaden that too much, we will dilute the funds that will be available on the reservation.

I do not profess to know how best to address that problem. You seem to be recommending that we do broaden it substantially.

Mr. **Powless**. I would recommend, as was indicated before, that the base for all these services is the tribes. The tribes should not be excluded out of these processes but should be a part of them. The tribes should be more involved in the development of these types of policies rather than excluding them or directing them as to what the policies are going to be. Let the Indian people be involved in the process.

Senator **Melcher**. My experience has been that when the tribes do address the problem, they say concentrate on the reservation.

Mr. **Powless**. I think that depends on the tribe. If that is the way the tribe wants to go, then that is the way they will go. There might be other tribes that would feel differently and that would like to expand the services because of the way the land base is structured.

Senator **Melcher**. It depends on each tribe in each area.

As to the question of traditional medicines, you did not describe any traditional medicine. What are you talking about? Please provide us with several examples.

Mr. **Powless**. I am talking about herbs that are used by medicine men in treating the problems of Indian people. I guess I could go into a number of examples there.

Senator **Melcher**. What about peyote?

Mr. **Powless**. Peyote has been recognized as a legitimate drug in terms of being used for religious purposes.

Senator **Melcher**. Is it a traditional medicine though?

Mr. **Powless**. Pardon?

Senator **Melcher**. Would you classify it as one of the traditional medicines?

Mr. **Powless**. Once again, I would have to plead ignorance or incompetence on that question because I am not familiar with peyote. I am only familiar with freedom of religion.

Senator **Melcher**. It is used that way.

Mr. **Powless**. I do not feel competent to address on how it would be used as a medicine.

Senator **Melcher**. I think any traditional medicine, herbs or otherwise, that can be recommended should be properly assessed. I do not think a lengthy process would be required for such an assessment.

We cannot instruct the IHS to use drugs that are prohibited and/or not approved by the Food and Drug Administration. There are beneficial drugs that are being overlooked. However, we have to look at this matter on a case-by-case and drug-by-drug basis if we want the IHS to consider their use. I do not think they can do it on their own. I will let them testify specifically on that point. The IHS only practices medicine with drugs that have been approved by the Food and Drug Administration or recognized as proper.

You raise a very interesting point though, and I would like to have some examples of specific drugs that you think could be beneficial. We could investigate the possibility of those being approved drugs.

Mr. POWLESS. I think we would be able to organize our medicine men of whom we are aware who participated in our conference and give you the opportunity to raise a lot of your questions with these medicine men at the hearings that will be conducted later on. We look forward to the opportunity to do that for the Senator.

Senator MELCHER. On the question of alcoholism, I would be very interested to find out whether or not transferring programs from the National Institute on Alcoholism and Alcohol Abuse to the Indian Health Service can be arranged and whether or not such a transfer would be beneficial in terms of additional funding.

I think we can make a strong case here in Congress that funds from the National Institute on Alcoholism and Alcohol Abuse would have greater relevance in terms of dollars per individual for Indians that would be the average. If this is meaningful for the IHS and it would be worthwhile throughout the country for Indian people, then I think we on this committee would be very much interested in pursuing it diligently.

Mr. POWLESS. I have had Indian people who have been actively involved in the alcoholism field bring to my attention the problem about the appropriations and the problem with lack of increases for these alcoholism programs. Some of them have stayed at the same funding level for a 5- or 6-year period in some instances.

Without any cost-of-living increases, there is a high turnover rate of staff. If people have been in the field for 5 or 6 years and are still living on a $12,000 or $13,000 salary that they had 6 years before with no increases, it becomes very difficult. The dedication of these people tends to expire. Therefore, because of these appropriation problems, we lose a lot of good people that have been involved in this field.

Senator MELCHER. I can easily understand that would destroy a good program.

I would like to see what we can do to have some continuity in that. The real success of such a program is continuity. Without that continuity, you lose so much potential. With continuity, there will be greater benefit per dollar spent.

If we have a commitment, if we have a goal, if we know that becomes a primary responsibility, and if the program is good, it is going to require increasing levels of funding up to a certain level. Perhaps after that plateau is reached and the preventive approach is effective, the funding level may go down sharply. There would be benefits for human life and the health of each human being as well as the benefit of reaching the real goal of the program where alcohol abuse does not remain a constant problem.

I very much support you on that. I think we can develop strong support within this committee for the programs. If IHS turns out to be the best agency for delivering the programs, that would be a very strong point for the Indian Health Service. It would represent a substantial accomplishment of public health on Indian reservations, and for Indian people off reservations, too, if that is a policy we adopt.

Thank you both very much. Your testimony is excellent.

Mr. **Powless**. Thank you.

Mr. **Press**. Thank you.

Senator **Melcher**. Our next witness is Dr. Everett Rhoades, Association of American Indian Physicians.

I understand you are the founding president of the association, Dr. Rhoades.

STATEMENT OF DR. EVERETT RHOADES, FOUNDING PRESIDENT AND CURRENT BOARD MEMBER, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

Dr. **Rhoades**. Yes.

Senator **Melcher**. How do you want to present your testimony, Doctor?

Dr. **Rhoades**. I am sorry, Senator Melcher, would you repeat that?

Senator **Melcher**. How do you want to present your testimony?

Dr. **Rhoades**. I have added a summary of our recommendations beginning on page 16. I have divided these up into topics somewhat like the representatives of the National Indian Health Board. I would like to make an introductory preamble to this and summarize some of the highlights of these recommendations, if that is all right.

Senator **Melcher**. Fine. Your prepared statement in its entirety will be made part of the record.

[Material follows:]

STATEMENT AND TESTIMONY OF EVERETT R. RHOADES, M.D., PROFESSOR OF MEDICINE AND MICROBIOLOGY, UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER, OKLAHOMA CITY, OKLA.; MEMBER, KIOWA TRIBAL COUNCIL; BOARD OF DIRECTORS, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS; VICE PRESIDENT, ASSOCIATION ON AMERICAN INDIAN AFFAIRS

Mr. Chairman, distinguished members of this committee, my name is Everett Rhoades. I am a professor of medicine of the University of Oklahoma College of Medicine, a member of the Kiowa Tribe, a member of the board of directors of the Association of American Indian Physicians, and vice president of the Association on American Indian Affairs. I am chairman of the Health Committee of the last organization.

It is an honor and a privilege to appear before this group, especially to discuss the current status of Indian health care and the relationship of the Indian Health Service to that care. Both of the organizations that I am with have given considerable thought and discussion to the matter before this Committee and have expressed their opinions in a number of ways in the last several years before the U.S. Congress and in other forums. Both organizations took an active interest in the development of the Indian Health Care Improvement Act of 1976. We believe that consideration should be given to the following factors in any evaluation of Indian health.

THE INCREASING BURDEN OF STUDIES AND INVESTIGATION ON THE INDIAN HEALTH SERVICE

There is probably no agency, with the possible exception of the Bureau of Indian Affairs, which is subject to as much study, scrutiny and investigation as the Indian Health Service. As I prepare this testimony, I have at hand a number of studies, reports, investigations, Congressional hearing reports, etc., the great bulk of which are somewhat repetitious.

A Committee of the House of Representatives is completing, or has recently completed a study of IHS operations. Periodically the General Accounting Office conducts extensive studies. In general terms, these reports tend to indicate that

IHS is performing its tasks reasonably creditably, with the various constraints placed upon it.

In fact, the annual appropriations process provide fairly thorough oversight hearings of IHS functions. The justifications for budget expenses are detailed and thorough.

The multiplicity of all these studies seriously interferes with the administration of IHS. The director must more or less continuously be preparing for some study or other. We hope this fact will be considered in the conduct of these hearings. These hearings have been widely perceived as being primarily for the purpose of reviewing the Indian Health Service; and as such they are being considered as a valuable tool by many who have a special political purpose in mind. It would be very useful for this committee to clearly state that the hearings are for the purpose of reviewing Indian health; not just the Indian Health Service.

INCREASING SIZE AND COMPLEXITY OF INDIAN HEALTH SERVICE

In the provision of health care to any individual the first consideration is the presence of a highly skilled and compassionate physician who provides care personally, or supervises the care provided by other health professionals. Of all factors, this is the most important. The reason for mentioning this fact is that in the very rapid development of the Indian Health Service from a basic provider of health care to an environmental engineer, to a sanitation engineer, to a community developer, to an advocate for Indian people, to a contract officer, there has been an obvious and inevitable undermining of this primary consideration. All of these other activities are useful and important as they are, have increased the complexity of the Indian Health Service dramatically. More importantly, many of these added responsibilities have not been coupled to adequate financial support for their execution. Thus, many people in the Indian Health Service are having their attention diverted from their primary responsibility to activities for which they were not necessarily trained and to which they frequently may have less interest. The field of contracting is a good example of the fact that Congress has placed added responsibility upon IHS without providing adequate support.

This diversification of the Indian Health Service, while it has made it a unique organization has had the inevitable result of increasing dissatisfaction both within and outside the Indian Health Service. Attention to this unique administrative and professional mix should be given in subsequent field hearings. Indian Health Service is often thought of as a health maintenance organization, an HMO. Indeed Indian Health Service is an HMO, but it is incorrect to compare IHS with any other existing HMO that I know about. There is no HMO which compares in complexity and extensiveness with the Indian Health Service. It is also fair to say that there is no other HMO in existence which shares the complexity of interrelationship between the provider organization and its constituents and consumers, as does Indian Health Service. Contrary to what many Indian people believe, input and advice provided by consumers to the Indian Health Service is much more extensive than for any other provider system of which I am aware. The establishment of Indian Advisory Boards at the service unit, area, and the national level is unique and provides for an extraordinary interchange between consumers and the Indian Health Service. Notwithstanding a number of complaints about IHS which arise through these Advisory Boards, in my opinion the limiting factor is not within IHS but on the contrary is often within the Boards themselves. Some of these deficiencies include inadequately informed and trained individuals on the Health Board, incorrect perception of the role of Health Boards in guiding Indian Health Service, confusion as to representation within Advisory Boards based upon variations and selection of representatives from tribes, politicalization of Health Boards diverting them from their primary mission, and finally the selection of inappropriate staff to administer the Boards. All of these are factors of considerable consequence interfering with the function of the Health Boards themselves. In many instances, the Health Boards are not satisfied to be advisory to the Indian Health Service, a situation in which the present status of legislation would seem to make necessary, but some Boards have expressed an interest in actually taking over the actual operation and direction of Indian Health facilities. The latter situation in my opinion would be devastating and chaotic and very detrimental to Indian health.

We have repeatedly said that the major deficiencies existing within Indian Health Service would be readily correctable with adequate funding. The responsibility of this, of course, must lie directly with Congress and not within Indian Health Service. We do not need to point out that the authorizations for expenditures under the Indian Health Care Improvement Act have not been forthcoming from Congress. Therefore, it is hardly reasonable to blame the Indian Health Service for these shortcomings.

CONSUMER SATISFACTION

One must interpret expressions of dissatisfaction with the Indian Health Service by consumers very, very carefully. For example, in the last year or so, during discussions of the need to reorganize or even to abolish the Bureau of Indian Affairs, in spite of universal expressions of dissatisfaction with the BIA, Indian people quickly became agitated at the thought of obliteration of the Bureau of Indian Affairs. As a matter of fact, kicking of the Bureau of Indian Affairs and the Indian Health Service sometime reaches the level of sport by certain Indian people and groups. None of them really want an abolition of either of these organizations. It is necessary to mention this fact because in the unstable situation that America is in at the present time, and the searching for alternative solutions for difficult problems, it is possible that there may be individuals who would recommend abolition of the Indian Health Service. The impact, for example, that National Health Legislation might have on Indian Health Service is potentially incalculable. If there were no Indian Health Service and if the United States were to sit down today to build a health system for Indian people it would be almost identical with that of the Indian Health Service.

With all of these considerations in mind, we maintain that the most important evaluation to make in consideration of the effectiveness of IHS, is the actual health condition of Indian people as impacted upon both by the Indian Health service and by themselves. That is, complaints and dissatisfaction by individuals must be weighed very, very carefully before making a determination that Indian Health Service is not being effective. It is extremely difficult to measure satisfaction. We have been involved in the investigation of too many "horror stories" that are based on misunderstanding of the actual facts by Indian people to believe that a recitation of these "horror stories" is in and of itself bonafide evidence of inefficiency or inadequacy of IHS. It is for this reason that field hearings must be very carefully evaluated, if they are to be used as an accumulation of hard evidence. There are few techniques better designed for demagoguery on both sides of the table than Congressional hearings. It often seems that almost every testimony, however, noncorroborated or how wild, is given credence and wide publicity with considerable deleterious effect. I have had wide personal experience in the Indian Health Service with family members who were patients, as a member of an Advisory Board, or as an occasional consultant. I have had over ten years experience as a physician within the Veterans Administration and over ten years experience in a large teaching center. It is my opinion that the "horror story" type of experience is no more common among Indian Health Service than among these other agencies, or even in the general medical community. What is different is the very active consumer group gives a much wider publicity to these kinds of experiences within the Indian Health Service. It is clear that in measures of health of American Indians for a number of disease categories, the activities of the Indian Health Service have been very successful. These data are widely available and summarized in the Task Force on Health Report of the American Indian Policy Review Commission of 1976. On the other hand, there are many situations in which the health of American Indians is appalling. This often is outside the ability of the Indian Health Service to influence. It might be added that tribal and Indian programs are not more successful in these areas (for example, alcoholism) than is the Indian Health Service.

THE PROVISION OF HEALTH CARE TO INDIVIDUALS

This topic should be the central concern of all the hearings and should be the most important measure of success. The requirements for providing good individual health care are too widely known and discussed to be reported here. This care depends upon a highly skilled, satisfied, physician (or other health worker), with adequate communication skills and empathy for Indian people. A great deal of attention has been given to providing this. However, the health worker is only one third of the requirement for a successful encounter. The health worker must also have adequate support systems such as laboratory and x-ray facilities along with other support including dietetics, physical and occupational therapy, etc.

However, there is an essential part to this encounter which has been widely overlooked: the patient. There are certain attributes of patients which influence the outcome of the encounter. A knowledgeable patient is much more apt to be helped by the system. In addition, the patient must be motivated to care for himself in a more efficient fashion than heretofore. The patient must have confidence in the system in order to obtain maximum benefits.

Recommendation

Explore ways to improve the ability of the patient to benefit from the encounter with the system. The patient must be educated about when it is *not* necessary to use the system. Ways of activating patients to self-care are of extreme importance.

Hearings are not a completely satisfactory way to evaluate the quality of the individual encounter between an Indian and a health provider. There are certain techniques for doing this. Some years ago the American Thoracic Society in conjunction with some state health departments devised the "consecutive case conference" as a way of evaluating the care of patients with tuberculosis. This technique could well be applied to other kinds of cases with the Indian Health Service and have a beneficial effect upon the care of Indian people.

INDIAN CONTROL OF THE HEALTH DELIVERY SYSTEM

An area that causes perhaps more complaints than any other is that of Indian control of health services. Unfortunately, The Indian Self-Determination and Educational Assistance Act should have been named something else. Something like the "Indian Contracting Act" would have more accurately described what the bill provides. This Act and its effects are still grossly misunderstood throughout Indian communities. Many Indians believe this bill actually converted their tribes automatically into fully competent domestic nations. This puts IHS in an awkward position and IHS gets blamed for the failed expectations as well as the impediments and irritations that arise.

Based upon experience within the Kiowa tribe at present, it would be absolutely chaotic for this tribe to assume control of its health program. Clearly, individual Indians would be no better off in the receipt of health care, and in fact, a great deal worse off. Even where one would expect that Indian-controlled programs would produce native health workers much more sympathetic to Indian clients, experience indicates that this isn't the case. Indian bureaucrats are just as insensitive to patient needs as are non-Indian ones.

Recommendation

This is an area worthy of examination. Even though there are several instances of Indians operating their own programs, there is little data to show that tribal health is improved as a result of this. Consideration should be given to the potential deleterious effects of transferring all Indian programs to tribes. If this took place what then would be the role of IHS? Even more importantly, what would happen to the trust responsibility of IHS if tribes operate their own programs. Would not this, in effect, remove IHS from trusteeship? Wouldn't such a situation really amount to termination?

This matter must be given very careful consideration in the development of any other alternative to IHS including of national health insurance or other forms of delivery systems.

Until the value of all alternatives to IHS are clearly demonstrated; and until the special trust relationship is reinforced and perpetuated, nothing should be done further to weaken IHS. This includes transfer of greater authority for operation of programs to advisory boards. It is our contention at present, that advisory boards should remain advisory in nature. Even in this role, a great deal more can be done to implement ideas from the boards.

ACCESS TO HEALTH CARE

The problems of providing health care to remote areas containing relatively small numbers of people has been thoroughly discussed. However, there are other problems of access to health care. In addition to a distribution problem is the fact that IHS is not provided with enough funds to provide all the services necessary for Indian people. This leads to need to set priorities as to what health services will be provided to whom. This is seen most often in the area of dental and eye care but is felt in virtually every field of medicine. A number of difficult problems exist in the mechanisms for setting of priorities. Surely the

Service Unit Board should be the primary instrument for setting these priorities and indeed they have considerable input, sometimes the major input as when the Service Unit Board at the Lawton, Oklahoma hospital voted to place out of state boarding school children at the lowest priority for care. This is a good example of a wrong decision being made by the advisory board. However, the physician responsible for providing care must also participate in this decision-making. Congress also has some input by setting priorities in the funding of specific programs such as streptococcal eradication programs in which, of necessity, a certain group receives the major consideration.

Adequate delivery of health care and the need to set priorities have led to a number of problems. One of these is the "on or near reservation" priority in the provision of contract care. *All* separation of Indian patients into various priority categories is objectionable, and there are always going to be problems associated with such an approach. There have been those who have argued that the IHS should set up some other system of selecting priorities of health care. None of these alternatives have seemed very satisfying. The least destructive way of setting these priorities is to take care of the patients on a first-come, first-served basis until funds are exhausted and then no more care can be given. This is better than in effect setting up classes of Indians.

Approaches to the provision of health care in a more stratified system should be considered. That is, IHS should be the primary provider, giving all ambulatory and routine hospital care. More complicated hospital cases requiring services and techniques which can never be provided to Indian hospitals should be provided by state institutions such as medical schools already equipped to care for complicated patients. This care should be provided at cost reimbursement rates to the IHS as part of the responsibility of the state. The recent court case, White vs. Califano, has been hailed as a victory for Indian people in that the role of IHS as the primary health provider for Indian people has been reinforced as part of its trust responsibility. However, it is not really a victory for Indian people at all, but a victory for the state of South Dakota which, in effect, was declared to have no responsibility for its Indian citizens at all.

Recommendation

This committee has a great opportunity to explore a very difficult and troublesome problem. Just asserting that IHS has got to solve the problem is not sufficient. It either has got to be given the funding with which to do the work, or some imaginative alternatives must be found. The "stratification" of Indian health care into levels of increasing complexity and sharing this care with other providers is a reasonable compromise which will permit IHS to continue to deliver health care in the Indian community which is done quite well. Tertiary and mental health care could be provided by state facilities already in place. The problem of providing care to the remote patient is simply one of transportation and communication which is a systems problem immediately solved with adequate funding.

ORGANIZATION/ADMINISTRATION OF IHS

One of the very easy problems for this committee to deal with will be what to do about the administration of the IHS. There has never been an area in which so many people were so sure of the answers. Every Indian in the U.S. is absolutely sure that he or she could administer the IHS without any problems. The rationale for this is that whatever it is that IHS is doing, it is bound to be wrong; therefore, the way to correct it is to just do something different. It may be predicted that most of the witnesses appearing before this committee will have comments about the administration of IHS. Many of the complaints that we have heard seem to originate from individuals who have not had their specific suggestions taken as seriously as they would have liked, regardless of merit or lack of merit. Many of the complaints about administration arise from non-Indian persons who have some special project of their own that they think will solve all problems of Indian health. For the most part these persons are neither health workers nor have they been in a position of having the responsibility for operating programs. Even staff assistants of congressmen are included in this group. During appropriation hearings for IHS last spring, I was witness to an extraordinary bit of lobbying by a congressional aide in which a group of Indian people were urged to begin a letter campaign to get these very oversight hearings instituted. This emotional aide beat on the table and said that she had been to the office of the Director of IHS every day beating on his desk trying to get him to change his ways. Such arrogance! Such condescension! Such patronage of

Indian people! Are we, through the guise of these hearings, being used to further some political ambition within Congress? Even if not, such haranguing and emotional involvement by a congressional staff person is highly suspect and casts a shadow over these very hearings.

There is probably no agency of federal, state or private organization which has such a diverse and vocal constituency as does IHS (perhaps with the exception of the BIA). There are numerous Indian and non-Indian organizations, governmental and private, sound and unsound, all of whom have some specific ideas about running the IHS.

Except for these vocal and special interest groups, the administration of IHS seems neither better nor worse than other agencies, including the United States Congress! I have had nine years of military experience, twelve years of experience with the Veterans Administration, many years of experience as a faculty member of a large university, and of more than one hospital and the biggest difference that I see between these and the IHS is that there are so many more experts who know how to run the IHS.

Most other complaints are for things in which administration gets blamed even though it may be beyond the control of IHS administration. Often, Indians with complaints do not understand the constraints placed upon IHS. In addition, there are special considerations of IHS which must be taken into account. An example of this was the recent disagreement between IHS and the House of Representatives committee on the proper bed: patient ratio that should be used in new hospital construction. The position of IHS was that a higher bed patient ratio should be used to take into account the greater need for longer hospitalization of Indian people made necessary by the great distances from the hospitals. We have seen this repeatedly in Oklahoma where a woman nearing delivery is required to come to the hospital before she is in labor to avoid having a baby delivered during transit. Thus, such special considerations are valid. I am disappointed that more Indian people haven't supported IHS in this.

There are two areas in which the administration might be profitably examined. The first of these is the policy of placing decision-making in the field instead of in the central office. The benefits of this policy lie in its provision of greater flexibility to meet the varied requirements encountered between different tribes. It would appear to be axiomatic that placing decision-making as near the people involved as possible is desirable. However, there are a few drawbacks to this policy. For a variety of reasons it often just simply fails to work. It is often bypassed by the tribes going directly to Washington anyway. Occasionally, there may be disagreement between IHS personnel in the field and those in central office. This policy has the unfortunate effect of sometimes appearing to lack any central direction.

The second area of concern lies in the lines of authority and communication. There are at least two lines of command from the field to the central office. One of these is through the directors of the service unit, area and central office. This would be the "traditional" track. However, there is another track, that through the various programs within each echelon, such as nursing, dietetics, engineering, etc. each of which has a line of command also through which decisions must flow. These separate lines of communication make for some degree of inefficiency throughout IHS.

Recommendation

This is a reasonable area for investigation. However, failing to take into consideration the special nature of Indian-federal relationship and the exceedingly complicated nature of Indian affairs could cause some very deleterious consequences. We reiterate at this point that the supreme test for IHS is the quality of care rendered the individual patient.

THE LIMITATION OF OVERSIGHT HEARINGS IN THE ANALYSIS OF INFORMATION

Congressional hearings, although useful in a variety of contexts, have certain limitations for the establishment of truth. Hearings tend to be patterned after courtroom procedure except that rigorous production of evidence is not always followed. Any demagogue may make all kinds of ill-founded assertions without adequate substantiation and have thus given the same attention as carefully collected and documented data. Congressional hearings are valuable however, as fora in which a variety of viewpoints may be expounded.

Adequate study of a given health encounter and the study of the adequacy of direct medical care requires a different kind of procedure.

The last senate oversight hearings of IHS were held only a few years ago, chaired by Senator Jackson, who I believe was preparing to run for the presidency about that time. I don't recall anything very definite coming from those hearings except for allegations that IHS was involved in some kind of genocidal conspiracy to sterilize Indian women. Have the findings of those oversight hearings been reviewed for their applicability to the present situation? If not, why not? If those hearings were not useful, then what steps are being taken to insure that the same deficiencies do not occur this time?

Recommendation

There is a certain, albeit limited, usefulness of oversight hearings. The enormous complexity of Indian problems that currently exist are such that hearings probably cannot adequately cover all of them. This being so, it would appear that some selection of problems should be made. If Congress is evaluating PL 94-437, the Indian Health Care Improvement Act, then isn't it acting perhaps prematurely in anticipating the report on this Act required of the Secretary of HEW?

SUMMARY

There is no issue as crucial to Indian people as the Trust status conferred by law or Treaty. It is imperative that this Trust status be maintained not only for the benefit of Indian people, but more importantly for the United States and Americans as a whole. It is important for the United States to honor and fulfill its solemn obligations. It is important for Indian people because the Trust status is the only certain way of preserving the philosophy, attitudes, and culture of American Indians. The reason why it is important for Americans to preserve these values is that they represent a view of life that is superior to that of the dominant society, and the dominant society must adopt these values if it is to survive. Thus, in truth, America needs Indian people in a way more than Indian people need America.

Attention must be given to the importance of this Trust arrangement and its fragile nature in any future direction given to Indian health care. The central role played by the Indian Health Service as the Trust agent for Indian health care must be preserved. Dismantling of the Indian Health Service will have a devastating effect upon the Trust status of Indians with consequences for American people far beyond the health status of individual Indians.

With this overriding concern in mind, we offer a few specific areas and matters that should be considered in future field hearings. These are presented in outline form.

A. The burden of the increasing number of studies on Indian Health Service:

1. This is a significant problem, affecting work capability and morale. An assessment of its impact should be made by this Committee and recommendations or guidelines given regulating future conduct of such studies.

B. Increasing size and complexity of Indian Health Service:

1. IHS is far more than the usual HMO and provides a great variety of functions including sanitation, research, community development, contracting, and others. A legitimate question is the potentially deleterious effects of these diverse activities on the day-to-day health care given to Indian people.

C. Consumer Satisfaction:

1. This is a treacherous subject, impossible to define or quantify. A careful comparison of consumer satisfaction of other health delivery systems should be made.

2. Even in the face of widespread complaints, Indian people especially at "the grass roots" undoubtedly would object to dismantling of IHS.

D. Provision of Health Care to Individual Persons:

1. This of course is the paramount consideration for any health delivery system. The individual encounter is so important, complex and subtle that it must be re-emphasized. This encounter probably is adversely affected by a number of factors including the altered role of IHS in the fields mentioned above.

2. The quality of the individual encounter is also extremely difficult to measure. We have suggested one type of study to do this.

E. Indian Control of Health Delivery Systems:

1. Extreme care must be taken to provide a thorough review of this important topic, some questions that should be answered include:

a. Will the health care of individuals be better under Indian controlled programs?

b. What precisely are the benefits of Indian controlled programs.?

c. What will happen to the Indian Trust status as a result of Indian control?

F. Access to Health Care:

1. Attention will have to be given to the possibility that there may never be enough funds to provide total care to everyone.

2. Alternative systems should be explored, such as making state institutions already in place more responsible for some aspects of care at a nominal cost.

G. Organization/Administration of Indian Health Service:

1. Attention should be given to the special needs of Indian people and how IHS is or is not meeting these needs.

2. Retaining considerable discretion and flexibility of programs is important.

H. Limitation of Oversight Hearings:

1. Keep in mind the very special importance of the Trust responsibility and the fact that health care to the individual is the supreme concern.

Dr. RHOADES. Let me identify myself further. I am Everett Rhoades, a member of the Kiowa Tribe of Oklahoma. I serve as vice president of the Association on American Indian Affairs also. I was incorrectly identified yesterday at a national meeting as former president of the American Indian "Positions," which I am happy to say is not carried over to today. [Laughter.]

More importantly, perhaps, I was born in an Indian hospital. There are members of my family who at the present time are being cared for in Indian hospitals in my community.

I have served on a service unit advisory board for our tribe. I have served on the area advisory board for the Oklahoma area. I serve as an informal, unpaid consultant to the Indian Health Service locally and see patients at the present time in the hospital in the western part of the State of Oklahoma.

The comments and perspectives I would like to bring before the group basically derive from that kind of experience rather than from a wide constituency.

The Association of American Indian Physicians now has about 100 members from a variety of tribes throughout the United States. We have spent considerable time discussing these kinds of problems. Therefore, I think I am bringing a kind of consensus of that group also.

I appreciate very much the opportunity to appear before this committee that has played such an important role in Indian affairs and Indian health. I have had a very pleasant and long association with Mr. Richtman, who participated with us when I had the privilege of being on the Task Force on Health of the American Indian Policy Review Commission. We view with a great deal of interest the upcoming oversight hearings.

One of the things that was not entirely clear to me was this, and perhaps it was reflected by the representatives of the National Indian Health Board also. I was not sure I had an opportunity to come here and tell the committee how to do its business in the upcoming hearings or whether or not you wanted to hear the solutions to specific Indian problems today. Therefore, I have taken the liberty of trying to do both.

From my experience and that of the association I am with, what should be kept in mind in any future conduct of this critical committee is that the paramount and overriding concern of Indian people at the present time is preservation of the trust status. You heard about that a while ago. I would like to emphasize that dramatically.

If the trust status is further eroded, basically what will happen is that one of the most precious natural resources that America possesses—that of its Indian people—will be largely diminished. It is clear to me that it is not just Indian people who will suffer if that is the case but. indeed. the United States will suffer.

Stated another way, in my opinion at the present time the very special viewpoint of the universe of Indian people and Americans in the world possessed by Indian people makes them absolutely unique. America in a way needs Indian people somewhat more than Indian people need America, although I do not want to push that very far.

One of the concerns I would like to bring to your attention is some consideration should be given to the fact that these very hearings, in my opinion, will fulfill what in the world of science and physics we call the Heisenberg uncertainty principle. If you try to measure electricity, the very act of measuring that electricity will alter the thing that you are measuring.

I think the tremendous burden of studies, investigations, and hearings that now have become continuous as far as the Indian Health Service is concerned is in very near danger of interfering with the functioning of the Indian Health Service itself. I do not say that in any way to suggest that these hearings are not important or should not be held. I just hope attention will be given to the fact that the Director of the Indian Health Service really spends an enormous amount of his time in what is largely repetitive explanations of why a certain thing was done.

As a matter of fact, the other day when I was preparing this statement, pulling out all the information that I could about the Indian Health Service, I very quickly achieved a stack of documents almost 3 feet in height just in the last 10 years dealing with all the different problems of the Indian Health Service.

For example, I believe one of the committees of the House of Representatives is now completing or recently has completed a study of Indian Health Service operations. The General Accounting Office conducts extensive studies from time to time.

As I suggested, many of these studies, even when they are well performed, tend to be somewhat repetitious. Perhaps there is not really an infinite number of problems with the Indian Health Service. Perhaps we should look at some sort of consolidation of these sorts of activities.

I would like to emphasize the rapid increase in size and complexity of the Indian Health Service. It has had an effect that has not just been reflected in increasing complexity but, in my opinion and in my experience in Indian Health Service hospitals in western Oklahoma, has had a direct detrimental effect, No. 1, on the morale of the professional health providers, and, No. 2, an interference with their basic mission—the basic mission being the provision of the best possible health service to an individual Indian.

I think we have even strayed in the last decade or so. I admit to being a participant to this. In this tremendous proliferation of activities we have tended to forget that health care really depends upon a highly trained, motivated, and empathic health provider, which may not need to be a physician but frequently has a physician as the captain of the team, and a somewhat knowledgeable recipient.

In all the hearings that come about we urge this also be given a high priority in the sense that the basic test for any program whatsoever should be what does it do for the individual in his encounter with the health system.

Many professional people in the Indian Health Service now serve as contracting officers, auditors, and all sorts of things for which they do not have the background and probably do not have the inclination to perform. Needless to say, with the addition of all these responsibilities to the Indian Health Service, the Indian Health Service has not been given the appropriate management support in order to carry them out. I do not have a good solution to that.

The record of the Indian Health Service in the field of sanitation, for example, has been really exemplary as far as Government programs are concerned. It should be maintained.

However, we would just like to point out this is a consideration which should be on the mind of Congress in carrying out these further studies of the Indian Health Service.

Frequently in the establishment of policy by the Indian Health Service the advisory boards themselves play a greater role than they themselves will admit. I can say that from having served on the first area advisory board in the State of Oklahoma. If this becomes a matter of consideration, which it should, then some evaluation has to be made into the adequacy of the advisory boards themselves.

As you have pointed out already, there is a variation in the selection of representatives from tribes and intense politicalization of the service unit boards and the advisory boards in my part of the country, which really has diverted them from their primary mission of providing advice to the Indian Health Service.

One of the important topics, which has already been alluded to, is what I describe as consumer satisfaction. It is keeping with the tempo of the times, at least of the 1970's, that the consumers really ought to be running their own programs. That is an assumption which I do not believe has a great deal of scientific validity in the sense that when this first began everybody said, "Indians know best what is good for them in the field of health." My experience is that is not a true statement.

Again I base that on my participation in my tribe's activities on the business committee and on the tribal advisory board. We often do not have the data with which to make a judgment. All other things being equal, obviously the decision should be made by the Indian people. I think we should continue to work toward that goal.

There is no question but that you are going to hear many, many horror stories. I started to put an example into my statement from reading a paper just the other day where some physician pulled the head off a baby at the time of delivery, which is hard for me to grasp but I suppose it happened. The reason why I want to relate that is that it did not happen in an Indian hospital; it happened in a private setting.

I have had over 10 years' experience now working in the Veterans' Administration part time as part of my academic appointment, working in large municipal hospitals, State hospitals, and large departments. My experience has been that the horror stories that are related are not greater in magnitude in the Indian Health Service than they are in any of these other health delivery systems. What is present in the Indian Health Service is an intensely vocal consumer group that brings all of these things to attention, which they obviously should be doing.

The point I would like to make is that satisfaction may be the most difficult thing in the world to measure. I do not know how to measure it. I would simply point out another anecdote which I thought was quite amusing.

Six or eight months ago the senior Senator from the State of Oklahoma said, "OK, I have now heard for 10 years about the need to close the BIA by all you Indian people. We now have an opportunity to reorganize it and close it." He was absolutely devastated by the enormous outcry that came from Indian people who said, "Don't touch our BIA." It is interesting that this is the first time in 10 years that I have really heard this.

The reason for emphasizing this is that I think there is a great deal of the same sort of sentiment that I detect across the country at the present time. I suppose it is a manifestation of the coming of age perhaps of the Indian Health Service. It is almost as much fun now to kick the Indian Health Service as it used to be to kick the BIA.

Again I think the best that one can do is to keep in mind that the measurement of consumer satisfaction can only take place in the context of the individual 1-to-1 encounter between a health worker and an individual, and whether or not the actual health of Indian people is impacted upon by the Indian Health Service or by themselves.

I have a very strong suspicion, which is not based on anything except my experience now, that a bureaucracy can only function as a bureaucracy. It cannot do anything differently. I can deal with that and not ask it to be other than a bureaucracy. I have a strong suspicion if we were to start from zero today, if there were no health program whatsoever for Indian people and the Indian people sat down to construct a system for health delivery nationally to Indian people, it would look very much like what the Indian Health Service looks like today, perhaps with some refinements.

What about the provision of health care to individual persons? As I say, this should be the hallmark of all programs. I do indeed think this has been lost sight of to some extent in the past 10 years, perhaps as a necessary accompaniment of the developing sophistication of Indian tribes as well as the increase in complexity of the Indian Health Service. However, this concern should be the central concern of all the subsequent hearings.

Attention should be given to the fact that based upon my experience as a tribal committee man, it is not clear to me at all that the health of Indian people will be in any way increased by transferring of programs to Indian tribes. Now, I am not arguing against transfer of control to Indian tribes. I do not want this to be interpreted that way. I just think it is important for Indian people to understand that if all the health workers were Indians, which I have also been pushing for, the health of the individual Indian really may not be changed whatsoever. One should not use that argument for it.

My experience is that the individual Indian person who comes as a supplicant to our tribal office is treated just as rudely by Indian people as in the Indian Health Service or the BIA. As a matter of fact, a good deal of the rudeness that is encountered by my family in going to the Indian Health Service and the BIA is from Indian people working in that system. Perhaps they have been assimilated too extensively.

It is a real opportunity, and we make a recommendation that this committee seek ways to explore improving the ability of the patient to benefit from the encounter with the system. There really has been a great deal of attention given to the quality of the health worker. It is not as good as it should be in the Indian Health Service, for a variety of reasons. I do not propose to go into that. However, it is not bad.

The buildings are not great. In some instances they ought to be condemned, but they are not bad. Attention has been given to those but almost no attention has been given to the patient.

Outside the Indian Health Service there are people who are working now on what is called the motivated patient and the activated patient, particularly in the field of aging. The patient may be much responsible for his own care than has been heretofore possible.

I visited an Alaskan village with Mr. Richtman when we were on the Task Force on Health in 1975. I asked one of the health workers, the equivalent of a physician's assistant, at a village in Alaska, "How many patients that come to see you every day really could be cared for at home by themselves if they had the appropriate knowledge?" The answer that was given to me was 90 percent, a figure which I have no way of disputing. Perhaps it is high, but you can see the impact of the enormous load that is imposed by individuals insufficiently knowledgeable of their own care. This is an area that I think could be approached much more effectively than at the present time.

I have some concerns that hearings as they are conducted are incomplete techniques for the acquisition of knowledge, particularly as it relates to the individual health provider.

Some years ago the American Thoracic Society, in the days when there was complete confusion about how to manage tuberculosis, developed a technique for evaluating State sanitariums that were involved in the care of tuberculosis patients. They evolved what was called a consecutive case conference. Different experts from around the country were invited to come and spend a day or two just simply looking over cases that were presented in which the health provider did not have the opportunity to select out. Everybody agrees the consecutive case conference technique really put the treatment of tuberculosis in this country on a sound, rational basis.

Some kinds of techniques such as that might be adaptable to evaluating the health care of individual Indians in the system regardless of what the nature of that system really is.

As far as Indian control of the health delivery system is concerned, this area is one that I think is probably responsible for as many complaints as any about the provision of health services by the Indian Health Service.

It occurs to me that the name of the Indian Self-Determination and Educational Assistance Act is a wrong name. It should have been named something else, such as the Indian Contracting Act. That really would have more appropriately described what that bill actually provides.

This act and all of its effects are grossly misunderstood by Indians and non-Indians alike. Many of the Indians, at least in my tribe, believe this bill actually has converted my tribes automatically into a fully competent domestic nation. As a result of this, the Indian Health Service frequently is in an awkward position and gets blamed for a lot of the failed expectations as well as the impediments and irritations that arise.

I have a real concern, which I think is a matter of future debate, that I think this committee also should pursue. That is my overriding concern for preservation of the trust status that Indians experience with the Federal Government and what really will happen to that trust status if all the programs are transferred over to the tribes. I think the leap from Indian tribally controlled programs to termination is really a very, very tiny step.

We would recommend that this is an area worthy of further examination. Intense scrutiny ought to be given to those few instances where Indians do run their own programs. I believe there are now three hospitals that are run by Indian tribes. The one in Oklahoma sends a bill to Indian people, which is of some interest and deserves further discussion.

Another area that has caused a great deal of discussion in the past several years is the problem of access to care. This is involved with the business of on or near reservations. It has to do with prioritization. I think it is going to be a problem that is going to get bigger as the expectations of people and the needs get bigger, and the resources for taking care of those needs are going to become less.

Indeed, there is a need to set priorities as to what services will be provided to whom. We see and have lived with it for many years in the field of dental and eye care, but it is really felt in virtually every field of medicine.

Obviously, the service unit board, if not the tribe, should be the primary instrument for setting these priorities. Indeed, the service unit board on which I have served has had a great deal of input into setting these priorities.

For example, one of the first actions we took when I was on the service unit board at the Lawton, Okla., Hospital was that we voted to place all of those out-of-State boarding students in Fort Sill Indian School and Riverside School at the lowest priority for care in our institutions. I am happy to say I voted against that. It is an example of a wrong decision being made by an advisory board, but that responsibility was placed with the advisory board and was carried out by the Indian Health Service to some extent.

It is not just in the field of Indian problems and Indian health, but the fact is that in this year as we are beginning to approach the end of this century, and as a matter of fact the end of this millenium, it is clear there is an analogy of Indian health to that situation some years ago in which there was a lifeboat that was overloaded and the captain of the lifeboat had at gunpoint to either kill someone on that lifeboat or force them over the side or else everybody would go under. That led to enormous interesting discussions of ethical problems of an overloaded system. I do not think it is an exaggeration to think that we are at that point at the present time.

For example, if we diverted the major part of our activities toward alcoholism, which has been expressed to be the No. 1 concern, in effect we might have to make the decision of diverting funds from a problem in which we possess all the knowledge to eradicate it to one in which it is not clear at all what the success rate would be.

For example, there is a streptococcal eradication program which has been enormously successful in preventing the complications of streptococcal infections, such as rheumatic heart disease with its very severe consequences and glomerulonephritis, kidney failure.

All we have to do is identify all of the people who need penicillin and give them penicillin at the appropriate time, and that could be eliminated. It still is a significant problem on the Navajo Reservation.

In the setting of priorities there has been ever so much more discussion than has taken place in the past as to what are the practicalities of those priorities and what can really be done. It is one thing to say that the problem is the No. 1 problem; it is another thing to devise a systematic successful approach to that.

One of the problems that we would suggest considering in the field of access to health care impacts on sovereignty, trust status, the relationship of the States to Indian Health Service, and so forth. Just as I would like to extend the lifeboat analogy, I do not believe that Indian Health Service can ever take care of all of the health needs of Indian people. I am not sure that much money is in existence. There certainly are many areas where there is already in place a mechanism for caring for some of these.

An example has been in the field of mental health. I do not think it makes good sense whatsoever to invent and devise a whole new mental health program for inpatient care of American Indians when there already is in existence in every State in the Union such a mechanism.

A recent court case in a northern Plains State, *White* v. *Califano*, has been widely hailed as a victory for Indian people. Basically, as I understand it, the court told Indian Health Service, "It does not matter whether you can do it or not. You have the trust responsibility, so go do it." Everybody says that is good, that the Indian Health Service should be forced to do it.

However, I do not really regard this as a great triumph for Indian people or the Indian Health Service because basically what it did was to say the State has no responsibility for its citizens whatsoever. What has been left out, of course, is the doctrine of dual entitlement. The problem is that Indian people fall between the cracks of the State and the Indian Health Service. I think that problem is approachable.

As the complexity of medical care gets greater also, it makes sense to make Indian Health Service continue in the present role as primary provider of health care for problems that come to it. There is tertiary type of medical care—dialysis for kidney failure, heart transplants, and various kinds of vessel problems—where a perfectly satisfactory arrangement could be made between States and the Indian Health Service that would not endanger the trust status of the Indian people. If it were carried out appropriately, which I think it could be, it would not really infringe further upon the tribal sovereignty either. I only suggest that perhaps a stratification of health care would be one way to approach this.

As far as organization and administration of Indian Health Service is concerned, this will be the easiest problem for this committee to solve. There is not one Indian in the United States who does not have the answer to that. Everybody I have met knows what to do about it. You will get all kinds of advice about it. Therefore, I really do not propose to discuss it further.

However, as has been suggested earlier, there is some blurring of lines of communication up through the system when one considers special programs. The example was given of alcoholism. Does the field-worker in the field of alcoholism report up the line through the service unit director and the area director to the Director, or does that person report to some alcoholism coordinator and so forth?

I have seen examples of this in almost every field—dietetics, engineering, sanitation—where it really is not clear just what the line of communication and responsibility may be. I think it is a topic worth pursuing further.

Let me close by bringing to your attention, Mr. Melcher, a letter from one of your constituents, a Blackfeet Indian who handed this to me on the way up here. Therefore, I do not have sufficient copies for everyone. However, with your permission, I would like to enter it as part of my statement and just summarize some of the points that he makes. I think it gives specific examples of some of this erosion of the function of Indian Health Services, at least in its symbolic nature as the trustee.

[Material follows:]

AUGUST 1, 1979.

Senator JOHN MELCHER,
Chairman of Senate Select Committee on Indian Affairs.

DEAR MR. MELCHER: I am an enrolled member of the Blackfeet Indian Tribe and am currently working in the Indian health field.

I am concerned with recent legislative efforts which although well-intended and certainly enable Indian people increasing control over their own programs, are eroding the very legislative base which makes their relatonship with the Federal Government a "unique" one.

Please include my concern with those of other Indian people who wish to see that every issue is surfaced impacting not only upon the delivery of quality health care to Indian people, but of equal importance, to the very legislative base upon which our Indian-Federal relationship is built.

Authorities for key personnel functions in the Indian Health Service have been removed and placed within the Regional Offices of the Department of Health, Education, and Welfare (HEW).

It is anticipated that financial management functions and authorities will not be too far behind.

Health Resources Administration (HRA) under Public Law 93–641 and through the U.S. Public Health Service has authority for health services facilities construction.

HRA under the same authority, also has program review and comment; interpretation of policy and administration of regulations is through HSA planning agencies.

Pursuance of Indian self determination under Public Law 93–638 and Public Law 94–437, through contracts, grants, and memorandums of agreement with Tribes and Tribal organizations.

While IHS can sometimes be taken to task for being less than progressive in its approaches, it seems to me that any program, much less a Federal agency charged with delivery health services to over one million Indian people cannot be expected, nor be held responsible and accountable without the express authorities to manage and control its own personnel and finance functions.

Without them the Indian programs would be dealing directly with HEW Regional offices and HSA planning agencies, rather with a legislatively based Indian program.

It would be an effective neutralization, at best; tantamount to castration, or "termination" of the special Federal-Indian relationship.

While I whole-heartedly support Indian self-determination and Indian involvement, not input, I accordingly ask that:

This trend toward fragmentations of Indian programs be addressed as a separate issue.

Indian Tribes, Indian organizations and Indian people be given the opportunity to view the above issue in relationship to overall efforts to Indian self-determination.

Copies of this letter will be given to various national Indian organizations concerned, not only with the delivery of quality health care to Indian people, but also concerned with the preservation of our sovereign rights and special legislative base.

Respectfully yours,

STEPHEN LABOUEFF, Jr.,
Health Care, Inc.,
Albuquerque, N. Mex.

Dear Mr. Melcher, I am an enrolled member of the Blackfeet Indian tribe and am currently working in the Indian health field.

Mr. RHOADES. He is not in the Indian Health Service.

I am concerned with recent legislative efforts which although well-intended and certainly enable Indian people increasing control over their own programs, are eroding the very legislative base which makes their relationship with the Federal Government a "unique" one.

Please include my concern with those of other Indian people who wish to see that every issue is surfaced impacting not only upon the delivery of quality health care to Indian people, but of equal importance, to the very legislative base upon which our Indian-Federal relationship is built.

Then he lists a number of things. I will not read all of them. However, for example:

Authorities for key personnel functions in the Indian Health Service have been removed and placed within the regional offices of the Department of Health, Education and Welfare.

In addition, he says:

It is anticipated that financial management functions and authorities will not be too far behind.

Health Resources Administration under Public Law 93-641 and through the U.S. Public Health Service has authority for health services facilities construction.

He lists a number of activities of the Indian Health Service that really are no longer within the purview of the Indian Health Service. This is a trend, the concern of which I share to some extent as it perhaps impacts on the trust responsibility.

With your permission, I would like to address a couple points which are not contained in my statement but that were brought out in the previous discussion and your questions of the Representatives who were here. However, I do not need to do that. That really concludes the points I would like to make in my statement.

Senator MELCHER. Thank you very much, Dr. Rhoades. I tend to agree with you on the outcome of hearings, discussions, and meetings. Sometimes we discuss, meet, and hear things to death without really resolving any key point. I think your observations are very well made not only in regard to that, but also with regard to the points that you have outlined here in your testimony.

I am quite pleased that you are active in this entire field because obviously with your background you have much to contribute.

I think you are correct in that I can remember, in my lifetime, at least three different eras when Indian people wanted to eliminate the BIA. However, they defended the BIA whenever they thought its continuance was jeopardized.

I suspect the same is true, as you say, of the Indian Health Service. If we did not have it and we started from scratch, if we followed the general thinking and consensus of the Indian people of this country, we would still end up with something like the Indian Health Service.

I do not personally appreciate what I think is sometimes overwhelming and unjustified criticism of the Indian Health Service.

After all, they are trying to make their agency function properly. I believe the best delivery system we could create is the Indian Health Service. Given the trust status that we have for health care for the Indians throughout the country, I think this is the best vehicle with which to work. I want to work with it.

I very much appreciate your help and leadership in this field. I am sure, as the committee has relied upon you in the past, we are going to continue to ask for your guidance and rely on your advice in the future.

Thank you very much, Dr. Rhoades.

Dr. RHOADES. Could I just take one moment to address the traditional medicine question and another area I think is overlooked?

Senator MELCHER. Fine.

Dr. RHOADES. Again, I have had considerable, although limited, experience in working with medicine men in my own tribe in the care of individual patients. Traditional Indian medicine is not just herbs and a special kind of healing. It is an entirely different discipline and an entirely different approach to healing.

In my opinion it has many, many aspects which are clearly superior to what in my training encompasses "scientific medicine," which in a way is really kind of sterile. It is an approach to medicine which is at least the equivalent in many diseases, if not superior in many instances, to Western scientific medicine.

I do not have problems about the herbs. Quinine for malaria came from the cinchona bark used by Peruvian Indians for centuries. That should be pursued. As a matter of fact, there are people who are pursuing investigation of these much more.

However, what is really needed is a recognition of the professionalism of the traditional medicine man. There is no reason why they should not be on contract to the Indian Health Service to provide medical consultation, just as I am as an internist.

For example, they should be given faculty rank in the training program. The training program for Indian medicine men has to be supported. The last Secretary of HEW was quite interested in discontinuing it. I am talking about the specific program on the Navajo reservation, which my association has supported continually.

Those are the things in my opinion that are needed as a way of preserving the very special attitudes of Indian people that are so precious for the country. It is absolutely imperative that this be part of the delivery system.

Senator MELCHER. Well, Doctor, then I will be watching when the University of Oklahoma, where you are a professor of medicine, adds some traditional medicine men to the faculty.

Dr. RHOADES. I hope that you can look forward to that with some success. We already are using them, which has taken overcoming of some obstacles. I hope that when Dr. Rhoades becomes the first professor of American Indian medicine at the University of Oklahoma that my first faculty appointment will be a traditional medicine man. [Applause.]

Senator MELCHER. We will watch with a great deal of interest.

Dr. RHOADES. May I make just one comment about a research function for the Indian Health Service? This was put into Public Law 94-437 as an add-on. I cannot emphasize enough that basic research really is vital to answer the problems of Indian health.

The problem of gallbladder disease indicates that Indians behave differently in the relationship of their metabolism of biosalts. Perhaps it protects them against heart disease, which is really fascinating. If we knew the answer to those biochemical variations, we not only could do a great deal for Indian health but we would understand disease processes much, much more greatly.

I have a paper that is going to appear in the Journal of the American Geriatrics Society. We did a study of the impact of mental health on aging American Indians. In that study, which is a simple compilation of data, we found if you separate Indians by decade of life the representation of their health matters is distributed unevenly.

This can even be applied to the field of alcoholism. Four percent of all the alcoholism problems in the Indian communities are made up by those who are under the age of 19. As this goes on the disproportion gets much, much greater. In the age group between 45 and 55 years of age there are three times more visits for alcoholism than what that proportion of the population contributes. Then it drops off dramatically. The elderly really do not have these problems, at least as reflected in visits.

One hypothesis, a guess, is that it might be that people are marked early in life to manifest a disease later on in life. I think there is some evidence in the Indian world that might be the case. If we could just keep these statistics for decades of life in very longitudinal fashion, we might really unlock some of the problems of alcoholism, for example.

The reason for bringing that up is that the present abilities of the Indian Health Service do not permit that. They collect some fantastically important and extensive data, but they do not have the facilities with which to keep those data for subsequent analysis. A very little additional support for their research program would permit those kinds of things. Again I emphasize the value not just to Indian people but to the rest of the United States.

Thank you very much.

Senator MELCHER. I would assume, Doctor, that they have the opportunity and certainly do follow through—I hope they do—working with the people in Atlanta at the National Disease Center. All of those data are extremely important. As you know better than I, those data unlock a great deal of unknown information which is valuable not just for Indian people but valuable for all.

I sympathize and agree with your idea of specific research. I, as a veterinarian who practiced for 20 years, have many ideas of where we were not getting the research done. However, you know as well as I do, maybe even better, that if we want research done we have to clearly demonstrate the line of interest and the line of real value for the research.

I applaud you for your efforts and encourage you very much. However, I know very well, probably almost as well as you do, that it is difficult to obtain the funding for all the research that we individually see as being extremely important. Your judgment is good and is not to be questioned, just as my judgment as a veterinarian was good and not be questioned. However, we did not always conduct the type of research and acquire the type of data we wanted.

I certainly will have an interest that the IHS does have the capability of relating data to the National Disease Center at Atlanta. I am going to make a mental note to talk to some people down there, both with the IHS and the National Disease Center about whether they really do have a good working relationship. It is extremely important.

Dr. RHOADES. Yes, it is.

Senator MELCHER. Thank you very much.

Dr. RHOADES. Thank you.

Senator MELCHER. Now we have a panel of the following witnesses: Eugene Crawford, executive director, National Indian Lutheran Board; Rev. David R. Adair, program director, Oklahoma Indian Missionaries-United Methodist Church; Don Reeves, legislative secretary, and Jan Harmon, legislative assistant, Friends Committee on National Legislation; Rev. James West, National Council of Churches of Christ in the United States of America; and John Melcher, S.J., St. Francis Mission, National Jesuit Office of Social Ministries.

John Melcher is my godchild, my namesake, and my nephew.

I am glad to have all of you here.

Don Reeves, are you going to head up this effort? Are you going to mastermind it and coordinate it?

STATEMENT OF DONALD REEVES, LEGISLATIVE SECRETARY, FRIENDS COMMITTEE ON NATIONAL LEGISLATION

Mr. REEVES. We are pleased to be here this morning, Senator.

You have in front of you, I think, what we have called a statement of concern which has been endorsed by 18 different religious fellowships, including the people who are here at the table and several other people who are in the hearing room this morning.

We will not take time to read very much of this statement. It seems to me in some ways a very general statement, which you would expect if 18 groups signed it. However, it is a general statement that comes out of specific knowledge of specific concerns. It deals with real people, real places, and real situations.

It is a statement of support for the initiative that the committee is taking in looking at the matter of Indian health care and the authorizing function.

Senator MELCHER. Your prepared statement in its entirety will be made part of the record.

[Material follows:]

TIME FOR A REVIEW OF INDIAN HEALTH CARE

A "Statement of Concern" to the Senate Select Committee on Indian Affairs, August 2, 1979, on behalf of the following:

June Totten, Director of Governmental Relations, American Baptist Churches, USA.

Ruby Rhoades, Washington Representative, Church of the Brethren.

Don Reeves, Legislative Secretary, Friends Cmte. on National Legislation.

James E. Wood, Jr., Executive Director, Joint Baptist Cmte. on Public Affairs.

Charles V. Bergstrom, Office for Governmental Affairs, Lutheran Council in the USA.

Delton Franz, Director, Washington Office, Peace Section, Mennonite Central Cmte.

Mary Cooper, Assistant Director, Washington Office, National Council of Churches of Christ, USA.

Eugene Crawford, Executive Director, National Indian Lutheran Board.

Gaspar Lo Biondo, S.J., Director, National Office of Jesuit Social Ministries.

George A. Chauncey, Washington Communicator, Presbyterian Church in the US.

David Saperstein, Union of American Hebrew Congregations.

Robert Z. Alpern, Director, Washington Office for Social Concern, Unitarian Universalist Assn.

Paul Kittlaus, Director, Washington Office, Office for Church in Society, United Church of Christ.

Joyce Hamlin, Secretary of Office of Legislative, Affairs, Women's Division, Board of Global Ministries, United Methodist Church.

Rev. David R. Adair, Oklahoma Indian Missionary Conference, United Methodist Church.

Robert Barrie, Associate Director, Washington Office, United Presbyterian Church.

American Jewish Congress.

NETWORK.

Further information: Jan Harmon or Don Reeves, Friends Cmte. on National Legislation, 245 Second Street, NE., Washington, DC 20002, (202) 547-4343.

Time for a Review of Indian Health Care

We are here today as representatives of concerned religious groups. We speak from a strong moral concern for the health and lives of Indians. It is our hope today that we and others can raise the issues, as we see them, involved in providing adequate health care to Indians living both on and off the reservations. We raise here some questions that need further exploration and collection of data before solutions can be found or answers given. There will be other questions not raised here that need to be asked as well. But we are confident that, as future hearings are conducted, this Committee will be given a clear sense of the steps which should be taken to improve the level of Indian health and will report appropriate legislation to the rest of Congress as soon as possible. Senator Melcher and members of the Indian Select Committee, we are grateful that you are taking this first step and that you have invited us to be here today.

Providing adequate health care for Indians is a problem which has never been resolved. The alarming statistics of Indian health show clearly that proper health care has not been a high enough priority of the federal government. In general, Indian health lags about 25 years behind that of the general population. Indians have the lowest life expectancy of any group in the United States. There is a high incidence of diabetes, obesity, and alcoholism. While the infant mortality rate among Indians has improved, it is still much worse than the national average.

The latest figures show that the Indian population is increasing two to three times faster than that of the general population, with one half of the Indian population under the age of 20. Meeting the health needs of this increasing, young population will require careful planning and sufficient funds to carry out those plans.

For these general, continuing reasons and for the following specific ones, we feel that your proposed series of hearings is particularly timely:

Authorization for the Indian Health Care Improvement Act expires at the end of fiscal year 1980. Public Law 94-437 set up a seven-year program, but in essence called for a Congressional review by limiting authorization to three years. Reauthorization will be required for fiscal years 1981 through 1984, or perhaps longer inasmuch as appropriations have fallen significantly below authorizations in each year of the program to date.

Section 701 of Public Law 94-437 calls for a review of Indian health needs during the last quarter of 1979. Partly in response to this requirement, and partly in response to the self-determination mandate of Public Law 93-638, nearly all Indian tribes have recently completed a tribal health care plan. Our initial reaction is that these plans are for the most part thoughtful and relaistic, and are a significant step toward Indian planning and participation in meeting their health care needs. We should think your Committee might want to include a review of these plans in your agenda, as a basis both for assessment and for conversations with tribal leadership. We understand that the Indian Health Service is reviewing these plans and that the plans will be a major element in IHS review of Public Law 94-437 (mentioned above—to be available about the end of this year).

An amendment (by Senator Domenici) to Public Law 95-626, the Health Services and Center Amendments of 1978, required the Secretary of Health, Education, and Welfare to report on Indian health care needs and services, with specific recommendations for improvements, by June 1979. We understand that this report has drawn extensively on these tribal plans and will be submitted to Congress during the next few weeks.

The issue of national health care or national health insurance may receive serious attention during this Congress. The special health care needs of Indians should be reviewed in that context.

Continued inflation and new food stamp and food commodity program regulations may have an especially adverse impact on Indian health and nutrition. Oversight hearings should include review of the implications for Indians.

The National Indian Health Board has just completed its third annual Indian/Alaska Native Health Conference. Many tribal leaders involved in the vast range of issues in Indian health care were present to discuss the problems. We are glad to be able to listen as they share with you reports prepared for that conference and resolutions and ideas coming from it.

REVIEW OF INDIAN HEALTH CARE IMPROVEMENT ACT

The Indian Health Care Improvement Act of 1976 (Public Law 94-437) is the most comprehensive Indian health legislation ever passed by Congress. It was designed to bring Indian health to an acceptable level, to help eliminate the tremendous backlog of medical cases, and to encourage Indian involvement in that process so that tribes can gradually assume control of health care for their people. This is consistent with the official U.S. policy of Indian self-determination.

Review of the implementation of the Indian Health Care Improvement Act near the end of its second year seems a necessary backdrop for considering reauthorization. To the extent that the goals of the Act have not been reached or approached, mid-course corrections should be recommended now to redirect implementation efforts.

Title I, Indian Health Care Improvement Act (IHCIA)—Proposed

Three years ago, there was a shortage of health personnel serving Indian country. For example, there was one physician per 988 Indians compared with a national average of one per 600 persons, or 40 percent less. At the time of enactment, there was a call for about 700 more Indian doctors, 270 Indian dentists, 1,700 Indian nurses, and 2,600 other health professionals. How many additional medical professionals are today serving in Indian health facilities? How many Indians are being trained as doctors, nurses, and dentists, and for other medical-related jobs?

The 1977 Report on the Need for and Feasibility of Establishing an American Indian School of Medicine, by the Dept. of Health, Education, and Welfare, notes that due to the high turnover rate (27 percent each year) for Indian Health Service physicians, there is difficulty in building trusting doctor/patient relationships. What are some ways to reduce this high turnover rate? An increased Indian physician training program? Improved staff living facilities? Upgrading medical facilities and equipment?

According to this report, "problems related to patient compliance, based in large part upon cultural differences between the American Indian population and non-Indian medical care providers," puts a strain on the present health care delivery system. It seems that these cultural differences would not be as much of a problem if there were more trained Indian personnel.

What causes inequities in the distribution of Indian health care delivery systems (personnel and facilities) which leave some areas with too few or no medically trained workers? Which areas need to be targeted?

Title II, IHCIA—Delivery of Services

In 1976, when the Indian Health Care Improvement Act was passed, several health indexes reflected poor health among Indians. The tuberculosis death rate was 4.6 times higher for Indians than for non-Indians. The death rate for alcoholism among Indians was 6.1 times higher. The infant mortality rate was 20 percent higher. Only 46 percent of Indian dental needs were being met. There was a backlog of over 13,000 cases of a middle-ear infection (otitis media) needing surgery. More than 188,000 Indians needed some sort of eye care. How have these statistics changed in the last three years? Has the backlog of cases diminished?

Title III, IHCIA—Health Facilities

At the time of passage, over one half of the Indian Health Service hospitals did not meet medical accreditation standards. How fast are facilities being brought up to standard?

Sanitation facilities needed much attention. In a 1976 survey of 9,450 Indian families, 20 percent had a known contaminated water supply. What progress has been made in correcting this?

How many Indian communities are still beyond easy accessibility of health facilities? What are the transportation and communication problems, and how can they be resolved?

Due to the lack of housing, staffing of Indian health facilities was a major problem. What has been done to improve the staff housing situation?

Title IV, IHCIA—Access to Health Services

All Indian Health Service facilities should be certified as eligible providers of Medicare and Medicaid programs. How many are now certified? Are Indians generally aware of their eligibility, and are they taking advantage of these services? How can eligibility awareness and utilization be increased?

Title V, IHCIA—Urban Indian Health

Are Urban Indian Health Centers adequately funded and staffed to meet the needs of their constituency? What has been the experience of urban Indian health projects in obtaining access for their patients to other federal-state-local health services. Have barriers been identified which need legislative attention?

A BROAD RANGE OF INDIAN HEALTH CONCERNS

Oversight hearings on Indian health care must go beyond a re-evaluation of the Indian Health Care Improvement Act. We offer the following as examples of other areas which need to be investigated.

> Many Indian illnesses, particularly chronic conditions, seem preventable. What resources, if any, are being devoted by the Indian Health Service to health education and prevention programs? Do these efforts include attention to possible special dietary needs of Indians, apparent greater susceptibility to diabetes, and the related factors of obesity and alcoholism? Is nutrition education being emphasized in schools? If not, how can this be done?
>
> Will Indian Health Service facilities and programs clearly qualify as health delivery vehicles in any emerging national health insurance program? What can be done now to assure that they will be eligible?
>
> Shared use of health facilities by Indians and non-Indians might seem appripriate where Indian communities are small, especially in sparsely settled areas. In instances in which Indian health care is contracted in non-Indian facilities, are services adequate and impartally given? Should consderation be given to non-Indian access to Indian Health Service facilities, assuming (revocable) tribal approval?
>
> The incidence of diabetes among adult Indians is very high (in some tribes as high as 50 percent). The National Diabetes Advisory Board was established by Congress in 1976 and has recognized the problem of diabetes health care among Indians. Acting upon the Advisory Board's recommendation, Congress appropriated for fiscal year 1979 $925,000 to the Indian Health Service to begin model programs in diabetes health care, control, and education. Can or should Congress do more now to reduce or help control diabetes among Indians?
>
> Since most uranium mining has taken place on and near Indian reservations, what can be done for Indians who have already been exposed to the health hazards that are involved with the mining or those associated with other energy development programs? What legislative measures could be taken to safeguard the rights of Indian communities to control further exposure to these dangers?
>
> It is clear that social and environmental conditions are part of good health. What is being done now and what else could Congress do in the way of mental health care? How could more emphasis in this field help reduce the rate of alcoholism? How are urban Indians' mental health needs being met to help with the adjustment of cultural dislocation and other problems they encounter? What steps should Congress take to see that Title II of the Indian Child Welfare Act (passed last year) is properly funded? This

would establish Indian family service programs to help eliminate the causes of the unnecessary and cruel break-up of extended families. What more needs to be done in the area of child abuse and neglect?

Could the suicide and homicide rates be reduced, if more attention were given to mental/sociological conditions? How can Indian trust in these services be achieved?

Title XX of the Social Security Act provides for the funding of social service programs through the states. Services provided include day care, foster care, and protective services for childern; counseling and family planning; and homemaker, chore, and meal programs for the elderly, all of which have impact on the health of the persons served. In the past, states have been reluctant to provide the required 25 percent matching funds for Indian programs and to accept tribal standards. This has placed Indian tribes at a serious disadvantage and has forced them into competition with local governments and organizations, which can provide input on how the funds should be divided among geographic areas and the various services. Should Congress amend Title XX to allow tribes to apply directly for Title XX monies and administer their own programs which provide assistance to the elderly, handicapped, families, and children?

In what ways is traditional Indian medicine being used in Indian health care? Is it recognized as important in the total health care of the patient?

Regulations have recently (June 19, 1979) been issued for implementation of the 1977 amendments aimed at improving the administration of federal food programs on Indian reservations. In view of the close links between health and diet, we hope the Committee will be alert to problems or successes of Indians' meeting their nutritional needs under the new regulations. We recognize that it is probably too early to draw definite conclusions.

The premise of our concern is that every individual has the right to adequate health care. By events now past, the United States has a particular responsibility to provide such care for American Indians. Congress has clearly stated this policy in the Indian Health Care Improvement Act (Public Law 94-437; sec. 3):

"DECLARATION OF POLICY

> "The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy."

We press Congress, through the Senate Select Committee on Indian Affairs, to reaffirm this policy.

We thank you for your time and offer our assistance as future hearings take place and initiatives develop.

Mr. REEVES. There is another dynamic here which I would call to your attention that probably is not appropriate to put in a formal statement. That is the dynamic that happens within what I call the religious community. This is a statement of acknowledgment of both moral and legal responsibility.

It is also a matter of educating ourselves. We do share concern for the matter of health care and other aspects of Indian life and culture, but those of us who are in national offices of our various fellowships have an ongoing responsibility to educate people. Therefore, in one way we have a bit of a selfish motive in contributing as we can to this process of exploration of Indian health care. In the process I think we would hope to convey some of the factfinding so that the members of our constituency can provide a better informed consent, advice, or criticism for the specific recommendations that hopefully will come out of this series of hearings.

You have mentioned the people who are here by name. I will ask Jan Harmon to call attention to what we think is the timeliness of this set of hearings. The other people in order of their speaking are:

Jim West has just retired as elected staff for Native American concerns of the National Council of Churches of Christ in America. He is undertaking a different assignment with the same body with the Interrelated Foundation for Community Organizers. He has had a role, I think, in the preparation of some of the tribal health plans that have been mentioned this morning and which will play a role in your hearings.

David Adair is the program director for the Oklahoma Indian Missionaries Conference of the United Methodist Church. He is a member of the Cherokee Indian Nation. He has been responsible for pulling together a group of health workers and others within the United Methodist Church. He wants to share some of that experience.

Within the Society of Friends we have an expression "weighty friends." I am not sure what all that means for Gene Crawford, but he is secretary of the Indian desk of the National Lutheran Council and executive director of the National Indian Lutheran Board.

We did not really start out for this to be a family reunion. We asked the Jesuits to help us find a person in the field who was knowledgeable about Indian affairs. They led us to one John Melcher at the Saint Francis Mission. It has been a delight for us to get a little bit acquainted with him this morning.

The person whose name is not on this list of witnesses is Gasper LoBiando, who is the director of the National Office of Jesuit Social Ministries. I have asked him to listen to the other statements that you will hear to help us fill in the gaps, I should think, and maybe promote a bit of dialog if time permits.

Jan, would you start us off, please?

STATEMENT OF JAN HARMON, LEGISLATIVE ASSISTANT, FRIENDS COMMITTEE ON NATIONAL LEGISLATION

Ms. Harmon. We are most appreciative to be invited to be here today. We feel that your proposed series of hearings, starting out here in Washington and then the proposal of field hearings to come, is particularly timely for a number of reasons that are mentioned in our written statement. I will just highlight a couple of those.

As you know, authorization for the Indian Health Care Act expires at the end of fiscal year 1980. Public Law 94-437 set up a 7-year program, but in essence called for congressional review by limiting authorization to 3 years. Reauthorization will be required for fiscal years 1981 through 1984, or perhaps even longer inasmuch as appropriations have fallen significantly below authorizations in each year of the program to date.

As was mentioned by representatives of the National Indian Health Board earlier, for the first time nearly all Indian tribes recently have completed an individual tribal health care plan. Our initial reaction is that these plans are a significant step toward Indian planning and participation in meeting their health care needs. We would think your committee might want to include a review of these plans in your agenda.

The issue of national health care or national health insurance may receive serious attention during this Congress. The special health care needs of Indians should be reviewed in that context.

We feel that oversight hearings should also include review of the newly signed food stamp and food commodity program regulations. We feel it is important to look at their implications for Indian health and nutrition.

There are other things that we could mention but these are the ones I will highlight today.

Mr. **Reeves**. I think I should say very clearly that the getting together of this statement and of this panel is principally the work of Jan Harmon, for which we are all grateful.

Jim West, do you want to proceed?

STATEMENT OF REV. JAMES WEST, NATIONAL COUNCIL OF CHURCHES OF CHRIST IN THE UNITED STATES OF AMERICA

Reverend **West**. Thank you, Senator Melcher and Don Reeves. Thanks, too, to the Friends Committee on National Legislation for coordinating this testimony today.

My name is Jim West. I am a citizen of the Cheyenne Nation and of the United States of America. My tribal nation enrollment is Cheyenne and Arapaho tribes of Oklahoma No. 5420.

I am here today representing the National Council of the Churches of Christ in the U.S.A., the NCC, which welcomes the opportunity to participate with this committee in its efforts to support Indian people in our struggle to improve our health conditions and, specifically, the health care delivery to Indian people by the U.S. Government through the Indian Health Service.

I would like to submit my written testimony to the committee for the record and will summarize that testimony at this time.

Senator **Melcher**. Your prepared testimony in its entirety will be made part of the record.

[Material follows:]

Testimony by the National Council of the Churches of Christ in the United States of America, Submitted by Rev. James L. West on Aug. 2, 1979

INTRODUCTION

Thank you, Senator Melcher and members of the U.S. Senate Select Committee on Indian Affairs. My thanks also to the Friends Committee on National Legislation for coordinating this testimony today. My name is Jim West. I am a citizen of the Cheyenne Nation and The United States of America. My Tribal nation enrollment is Cheyenne and Arapaho Tribes of Oklahoma No. 5420. I am here today representing The National Council of the Churches of Christ in the U.S.A. (NCC), which welcomes the opportunity to participate with this committee in its efforts to support Indian people in our struggle to improve our health conditions and, specifically, the health care delivery to Indian people by the U.S. Government through the Indian Health Services. (Please see attachment entitled "Relationship Statement to The National Council of Churches".)

Until July, 1979, I have been Elected Staff for Native American Concerns for the NCC. As staff for the NCC, I participated in the development of its current policy statement: Indian Affairs, adopted on November 4, 1978. I currently work with the Interreligious Foundation for Community Organization (IFCO) which supports Native American projects, both urban and reservation, as well as Native American Research Associates, a consulting firm, which has worked with several Indian nations in developing Tribal specific health plans.

I would direct your attention to The NCC Policy Statement: Indian Affairs, pages 19.2-4 to 19.2-5 "Affirmations and Declarations", sections (1), (3), and (6) which is attached. Section (1) states:

> "A primary objective of the democracy for which the United States stands must be the support of Native American nations and peoples to achieve full human rights as established by their tribal traditions and as protected by their national sovereignty. The National Council of the Churches of Christ recognizes a trust relationship between Indian nations (within the boundaries of the United States) and the U.S. Government. The NCCC recognizes

such a trust relationship to dictate a legal, as well as moral, obligation to support the full legal and human rights of Native Americans as individuals within their nations and the world. Such support for the human rights of Indian people includes the right to self government and the right to lead economically full lives based on adequate employment, housing, health care, and education, whether that be as tribal nations or as economically viable communities within the mainstream of American life. The trust relationship implies a commitment to support Indian tribes in their efforts to develop and re-develop their full potential as nations and to protect these developing nations against the encroachment of federal agencies, states or municipalities of the United States."

Further, section (3) states:

> "Adequate health care is the right of all God's children. Despite guarantees by treaty that the U.S. Government will insure adequate food supplies and adequate health care, many Indian people on and off federal reservations as well as a large number of Indian people not protected under such guarantees suffer from malnutrition and inadequate health care. The American churches have vastly inadequate mechanisms and methods for meeting domestic hunger needs and their root causes (especially those of Indian people) in relation to their much greater commitment to hunger relief worldwide. The National Council of the Churches of Christ will therefore begin to support Indian tribes in their efforts to claim adequate health care as well as provide leadership in insuring support for adequate food and health care through their own internal potential."

Further, Section (6) states:

> "The National Council of the Churches of Christ commits itself to support Indian nations, treatied or untreatied, in their effort to maintain their sovereignty as nations. As a part of the Christian church in the U.S., the NCCC urges the United States Government to recognize and respect the sovereignty of these Indian nations as established by law and any lands, jurisdiction and government properly claimed by such nations."

Based on this policy, the NCC would like to advocate for five statements and recommendations supportive of Indian people as this U.S. Senate Select Committee on Indian Affairs works to delineate major issues which should be addressed in health oversight field hearings.

Statement 1.—The NCC believes the federal government should be providing adequate health services through a comprehensive health delivery system to all Indian people. It further believes that the Department of Health, Education, and Welfare (HEW) through the Indian Health Service, is not fulfilling this commitment.

There is no basis in law for the federal government to exclude certain Indian tribes or Indian individuals from service eligibility. There are several laws which might be examined in order to construe congressional intentions regarding the delivery of contract medical care to Indian people. Included are the Snyder Act (25 U.S.C. § 13); the statute authorizing contracts for medical services with state and local governments (25 U.S.C. § 452); the Transfer Act transferring responsibility for Indian Health from the Bureau of Indian Affairs to the Public Health Service (42 U.S.C. § 201); the Indian Health Care Improvement Act (25 U.S.C. § 1601, et seq.); and the Appropriations Bill for the Indian Health Service for the fiscal year 1979, Public Law 95-465.

The American Indian Policy Review Commission in its final report points to the Snyder Act as "the basic legislative statement of the Federal Government's obligation to provide health services to Indians."[1] The Snyder Act states that:

> "The Bureau of Indian Affairs under the supervision of the Secretary of the Interior shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the *Indians throughout the United States* for the following purposes:
>
> "* * * For relief of distress and conservation of health * * *" (Emphasis added.) 25 U.S.C. § 13.

This language is plain and unambiguous.

In 1954, when Congress transferred responsibility from the Bureau of Indian Affairs to Public Health Service, (42 U.S.C. § 2002) it spoke of service and duties to "Indians" and "Indian people" and authorizes contracts with "any Indian tribe, band, group or community", pursuant to the Indian Self-Determination Act, 42 U.S.C. § 2004b.

---

[1] American Indian Policy Review Commission, final report, May 17, 1977, Government Printing Office, Washington, chapter 4. "Trust Responsibility," pp. 121-138.

Congress' most recent legislation on health care for Indians, the Indian Health Care Improvement Act (94–327), will probably be a specific focus of this committee's hearings. This act defines "Indian" as follows:

> " 'Indians' or 'Indian', unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of section 102, 103, 104(b) (1) (i), and 201(c) (5), such terms shall mean any individual who (1), *irrespective of whether he or she lives on or near reservation*, is a member of a tribe, land, or other organized group of Indians, including those tribes, lands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary." (Emphasis added.) 25 U.S.C. § 1603(c).

In spite of these facts, The Indian Health Service has developed a system of health care delivery which arbitrarily limits its patient population far beyond service eligibility spelled out in the legislation regulating this agency. Through memorandum and regulation, the IHS has interpreted service delivery systems to be systems limited by reservation boundaries and dependant on Indian persons present within those boundaries. This interpretation continues despite the reality that one of the significant reasons Indian people leaving the boundaries of their nations is to escape being victims of the devastating health standards. I assume this committee is well aware of the current health statistics for Indian people in this country. The vicious cycle continues as state, county and local agencies refuse to service Indian people on the basis that the federal government should be doing so through the IHS. The fact is that despite clear legislative guidelines, the IHS is moving closer to eligibility requirements based on the legally ill-defined status of "recognition" and on an Indian individual's presence within the boundaries of his/her "recognized tribe" (see attached letter to HEW Secretary Califano).

The NCC feels that such arbitary definitions of eligibility for health services by the IHS to Indian people are morally unacceptable in light of the trust relationship between the U.S. Government and Indian people. It is crucial that structures of congress responsible for oversight of health service delivery to Indian people strongly recommend that IHS develop plans for more comprehensive and inclusive eligibility requirements for delivery of health services to all Indian people throughout the United States.

Recommendation 1.—The NCC recommends that this committee investigate the present state of IHS eligibility standards and their relationship to the legislative mandates under which this agency is supposed to function; and it is further recommended that this committee seek out testimony from Indian people not currently considered eligible under IHS regulations.

Statement 2.—The National Council of Churches is alarmed at the recently promulgated HEW/Indian Health Service "contract care" regulations (42 C.F.R. p. 36). These regulations would appear to be yet another attempt by the Indian Health Service to arbitrarily limited eligibility in contradiction to congressional intention. Through these regulations, the Indian Health Service effectively denies most off-reservation Indian people fundamental health benefits for which they have been eligible in the past.

These regulations serve as a current and, unfortunately, timely example of the general case set forth in Statement (1) of this testimony. As has been clearly indicated above, there is no basis in law for such an arbitrary "cutting out" of health service delivery to 50 percent (or more) of the Indian population within the United States. Such regulations seem even more immoral in light of historical programs by the U.S. Government to displace the citizens of Indian nations from within the respective boundaries of these nations.

Who is responsible for these regulations? What is the legal basis for such arbitrary definition of Indian eligibility for health services from the U.S. Government? Are such regulations the result of decisions within IHS or further up in the HEW official hierarchy? What can the U.S. Congress do to positively enforce comprehensive and inclusive eligibility for Indian people under current law so that they receive competent and efficient health services?

Recommendation 2: The NCC recommends that this committee seek the answer to the above stated questions in its Indian health oversight field hearings; and it is further recommended that this committee seek out and include testimony from "off reservation" populations of Indian people in these same hearings.

Statement 3.—It is the position of the National Council of Churches that the potential positive effects of the Indian Health Improvement Act (94–437) and the Indian Self-Determination and Educational Assistance Act (93–638) have proven less effective than possible in improving health service delivery to Indian people. This is because HEW personnel have not developed the competency to respond to Indian Nation's efforts to plan for more comprehensive health service delivery. The NCC understands the intent of 94–437 to be the upgrading of health standards for Indian people to the health standards enjoyed by the U.S. as a whole. The Act's declaration of policy states that:

> "The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy." 25 U.S.C. § 1602.

This goal was to be reached through at least two mechanisms: (1) grants made available to tribes for tribal specific health planning and grants increasing tribal capability for health delivery; and (2) contracts provided by IHS to Indian nations to provide optimal health service delivery.

The Indian Health Improvement Act is well written in general and is an important step forward in improving Indian health in the future. The legislation does have at least one significant shortcoming, whose impact should be investigated. This legislation does not allow for training or technical assistance as regards tribal efforts to develop tribal specific health plans. This has had several significant effects. First, tribes who have had little to do with health service delivery are expected to have the capability of planning for such services. Secondly, tribes have had to utilize 93–638 allocations in order to get technical assistance for health planning. Thirdly, Tribes have had to rely on IHS personnel for technical assistance in health planning.

Having consulted with the Tribal Government Task Force of The American Indian Policy Review Commission, I have become aware of the mistrust by many Indian nations of 93–638, seeing it as another attempt by the U.S. Congress to terminate Indian nations. Therefore, many tribes have not utilized 93–638 for tribal specific health planning.

We have indications that some area IHS officers who might have provided technical assistance for tribal specific health planning have not. We would suggest two basic reasons for this lack of technical assistance by some area officers: (1) Prejudicial attitudes that Indian nations are incapable of planning and controlling health service delivery; and (2) a conflict of interest for many area IHS officers who are responsible for teaching Indian health personnel to take over their jobs.

As a consequence, some Indian nations with prior capability for health planning and service delivery and with writers, are improving their potential in these areas. Many tribes who have little capability for health planning and very poor service delivery are not able to utilize 94–437 (or 93–638) to improve their capability.

Recommendation 3: It is recommended that information concerning the scope and nature of 94–437 as well as 93–638 must get to Indian nations (e.g. so that tribes understand the opportunity for nations to plan for "splinter" and/or off-reservation population). It is further recommended that increased technical assistance should be made available to tribes by broadening current legislation. Indian nations should ultimately gain complete control by nations and/or collectively over the delivery of federal health services to their citizens within and without the boundaries of their nations.

Statement 4.—Alleged malpractice by Indian Health Service personnel continues to be a significant problem for the Indian population they serve. Attached please find letters addressed to me from DNA—People's Legal Services (Mr. Peterson Zah, Director) and South Dakota Legal Services (Ms. Anita Remerowski). These two legal agencies clearly state that this problem exists within their Indian client populations.

In addition, the Division of Church and Society of the NCC in conjunction with the Interreligious Foundation for Community Organization and the Joint Strategy and Action Committee/Indian Ministries Task Force has taken a clear stand against alleged sterilization abuse of Indian people by the Indian Health Service (see attached "Statement on Non-Medical Sterilization of Indian People").

The Indian Health Improvement Act does not allow for tribal control of physicians (either IHS personnel or contract personnel) working with their populations. It is suggested that without Indian tribal control over physicians practicing within their jurisdictions, that such malpractice will continue.

Recommendation 4: The NCC recommends that the quality as well as the quantity of health service delivery to Indian people by HEW be investigated, specifically including the occurrence of malpractice by direct and contract personnel of the Indian Health Service.

Statement 5.—As a Cheyenne with a deep belief in the traditional spiritual life of my people, and as an ordained minister of The American Churches, U.S.A. with a deep commitment to the ministry of Jesus Christ, and, finally, as a person who has spent three years in the University of New Mexico School of Medicine, I feel I am qualified to suggest that the time is long past due for any health service delivery system by the U.S. Government to Indian people to be sensitive to, supportive, and coordinated with the beliefs (both Traditional and Christian) of the Indian people it serves. NCC Policy states:

> "The National Council of the Churches of Christ recognizes that Indian peoples must have the freedom to seek full lives—spiritually, culturally, as communities and as nations. The Christian Church has a particular and theological perspective with regards to the liberation and fulfillment of Indian and non-Indian people alike as concerns these issues. . . The NCCC commits itself to seeking the above stated goals always in cooperation and consultation with Indian people so that each spiritual heritage, each political reality and each cultural uniqueness may communicate and share of its richness for the common good of all peoples. Christian churches work with the Almighty as the Kingdom of God is realized through justice and love always understanding that God is revealed to other peoples and cultures in many and diverse ways." (NCC Policy: Indian Affairs, "Summary", p. 19.2–5).

I have personally seen numerous examples of a lack of sensitivity on the part of IHS personnel toward the belief systems of Indian people. This is especially true as regards the traditional spiritual beliefs of Indian people.

Such a lack of sensitivity is not all malicious, but is often a result of inadequate recruiting and orientation on the part of the Indian Health Service. In contrast to this general trend, the Mental Health Unit of IHS in the Albuquerque area has shown the extent to which health care delivery to Indian people can be enhanced when the system delivering such service is sensitized to the beliefs and customs of its clients.

Recommendation 5. The National Council of Churches recommends that this committee investigate the extent to which the Indian Health Service has developed a system of health care delivery that is sensitive to the beliefs and mores of Indian people.

RELATIONSHIP STATEMENT TO THE NATIONAL COUNCIL OF CHURCHES

The National Council of Churches is a cooperative agency of 32 Protestant and Orthodox bodies in this country. I do not purport to speak for all members of the communions which are constituent to the National Council of Churches. I am speaking for the Governing Board, the policy-making body which is composed of persons selected by member denominations in proportion to their size. It is this group which determines the policy positions through which the Council seeks to fulfill its expressed purpose "to study, and to speak and to act on conditions and issues in the nation and the world which involve moral, ethical and spiritual principles inherent in the Christian gospel."

Attachment:

INDIAN AFFAIRS

National Council of the Churches of Christ in the U.S.A.

A Policy Statement
adopted by the Governing Board
November 4, 1978

INTRODUCTION

From time immemorial sovereign Indian nations have existed within what are now the exterior boundaries of the United States. These nations have social, cultural and economic values which are derived primarily from their spiritual understandings of the world around them. The Indian tribes generally are monotheistic and attach great significance to their relationship with nature. The earth is the source of subsistence for all creatures and each ultimately returns its substance in death.

The general spiritual approach to life and the physical environment has very specific implications for the world view of Indian nations and their peoples. Land, for example, is not treated as private asset, but instead, is shared communally by all members of an Indian nation. The land and the creatures which live on it are not to be exploited, but are to be taken and used only as an immediate need arises. From an economic viewpoint, Indians are communitarian in outlook and virtually without exception share food and other resources through ceremony and practice according to need within the tribe. The leadership of Indian nations is participatory in principles and leaders are chosen for a spiritual as well as political role. Finally, death is accepted as an integral and inevitable part of nature's cycle.

Each of the almost 400 tribes which exist in the United States, of course, has its own particular understanding of the general beliefs which have been described above. Each nation has its unique political and social traditions, as well as its own language and oral history. Thus, despite a spiritual commonality among Indian nations, each tribal culture possesses its own "way" and unique life-style premised on its relationship to God and the earth.

In addition to being discrete social, cultural and economic entities, Indian nations are sovereign political units whose control over their peoples and territory has been granted to them by their respective peoples. Members of each Indian tribe have historically conferred authorities on their government which have corresponded, in most instances, to executive, legislative and judicial powers as they are known in Anglo-American jurisprudence. Legislative authority generally exists in a council or, in many instances, in the total tribal group. Tribal elders or the selected leadership often serve a judicial function and are responsible for ensuring that disputes among members are settled fairly.

A CHRISTIAN HISTORICAL AND THEOLOGICAL PERSPECTIVE

The communions constituent to the National Council of the Churches of Christ in the U.S.A. have a history of concern and theological commitment to the Native American tribes in this country. This is not accidental but is grounded in love and justice of God. The National Council of Churches confesses that the Bible clearly reveals that God's justice in history is expressed as acts which have led nations and individuals out of captivity and degradation to liberation, fulfillment and the transformation which it calls salvation. Fulfillment is based on the minimal human rights of life's existence – the right to food and well-being, to housing, employment that is satisfactory, to live as healthy creatures and the freedom of people to relate socially and politically in ways that are consistent with their understanding of God, God's universe and themselves as God's creatures in need of total and ultimate authenticity. God's creation encompasses an infinite variety and diversity in all forms of life whose harmony and balance may be realized only through the fulfillment of their God-given potentials. It is in the context of God's total creation and through their understanding of this creation that Indian people claim for themselves the right to be respected and affirmed as people and nations of diverse gifts, characteristics and cultures. It is within the context of God's justice for all of his creation that Indian people seek self-determination and the right to attain fulfillment as a people.

The sovereignty of Indian people must also be understood within their own cultural and religious context. The sovereignty of Indian nations was affirmed in their God given self understanding, was experienced and enunciated in the context of their tribal cultures and was lived out on the land for which they have so much affinity. This is an interesting and theologically profound expression of the harmony between human beings and God's created order in contrast to the alienation often characteristic of other cultures.

Christian churches have historically assumed a spiritual, if not social, inadequacy of Native American people on which they have based their mission to Indian people. The nineteenth century notion of Indian peoples as "uncivilized," if not sub-human, was an idea that the Christian church nurtured and sustained. Some representatives of the Christian mission to Indian people have realized the shortcomings of such assumptions and have attempted to temper the destructive effects that have been a potential of their Christian "witness" to Native Americans. A few individuals have even recognized the authenticity of Indian spiritual life and its potential significance for the ethical system of Christianity as well as the value system of this country. The National Council of the Churches of Christ affirms those members of Christian churches who have worked to be open to God's revelation to Indian people and have worked to make their Christian mission a true sharing, both spiritually and institutionally.

The NCCC also recognizes with shame and contrition the responsibility of other members of Christian churches who, historically helped shape and carry out policies which have continued to alienate the Indian community from its search for fulfillment. Christian churches have played a direct part in the destruction of Indian nations. The federal government, for example, made numerous agreements in the early nineteenth century with groups such as the Board of Indian Commissioners which affected the appointment of missionaries as federal Indian agents. The "Peace Policy" established in the 1860's and implemented by President Grant repeated the essence of the earlier agreements with specific missionary groups. The General Allotment Act of 1887 statutorily recognized as a priority the establishment of mission schools on Indian lands "to civilize and Christianize the Indians." The Christian church with such a history of unholy alliances must share a great deal of the responsibility, not only for the sinful dehumanization of Indian people, but in the overall attempt by the U.S. Government to politically subjugate and culturally destroy Indian Peoples.

THE CURRENT STATUS OF INDIAN NATIONS AND COMMUNITIES

Indian Nations: The sovereignty of most Indian nations has been confirmed by federal statutes, treaties and agreements. In recognition of their status as sovereign in the United States' principal mechanism for conducting relations with the Indian nations was — until the late nineteenth century — treaties entered into between representatives of the federal government and the Indian nations. Although many treaties were the aftermath of successful military campaigns against Indian people many have been made after purely peaceful confrontations, and others have been entered into after Indian victories over invading forces.

The statutes, treaties, and agreements confirm a number of specific political rights and prerogatives which inhere in Indian nations as the result of their sovereign status. The Indian nations are recognized as holding rights of possession with respect to vast areas of land and territory. Tribal governmental authority over property and all persons residing on Indian lands is confirmed explicitly in many treaties and agreements. The authority of Indian nations to control and regulate those traditional activities essential to the continued viability of Indian culture, such as hunting, fishing, and gathering, is recognized on repeated occasions. The treaties, agreements, and statutes setting aside areas for Indian occupancy implicitly reserve for the Indian nations a quantity of water sufficient to ensure that tribal lands can be utilized for the purposes chosen by the tribes, including subsistence, agricultural, industrial, or other uses.

Although the foregoing treaties, agreements, and statutes constitute an explicit recognition and confirmation of the numerous powers of self-government possessed by Indian nations, they do not create or grant these powers, which are attributable solely to the status of Indian nations as sovereign. Thus, the absence of such recognition or confirmation in the form of a treaty, agreement, or statute in no way implies the loss of an Indian nation's sovereign rights.

The treaties, agreements, and statutes referred to above, as interpreted by the courts, define the trust relationship which historically has existed between the United States and Indian nations. This relationship imposes upon the federal government a duty to exercise the care of a fiduciary in protecting and assisting in the management of all assets, such as tribal lands, which the United States holds in trust for Indian nations. The trust relationship between Indian nations and the United States also imposes upon the federal government a far broader moral obligation to promote the general welfare of Indian nations, including the health and education of their members, and to defend the nations against political encroachments by federal agencies, states, or local governments which are inconsistent with the Indian nations' sovereign rights.

By all accounts the history of the United States' treatment of the Indian nations is replete with dishonor. The federal government began encroaching upon the sovereign rights and prerogatives of Indian nations within years after solemn treaties and agreements guaranteeing such powers had been entered into. In the early nineteenth century, for example, President Andrew Jackson chose to ignore explicitly a U.S. Supreme Court decision upholding the Cherokee Nation and, in blatant violation of treaty provisions, removed the Cherokee Nation from its land. The General Allotment Act of 1887, which is commonly referred to as the Dawes Act, resulted in the breaking up of communally-held tribal property into individual, privately-owned allotments – an overt attack on a communal people which ultimately proved futile. The Major Crimes Act and the General Crimes Act, which were enacted in the nineteenth century, represented an effort by the United States to increase the federal presence on Indian lands at the expense of tribal judicial systems. The Indian Reorganization Act of 1934, which was intended by Congress to rejuvenate and strengthen Indian Governments, nevertheless also enhanced the influence of the Secretary of the interior over tribal affairs. In 1953 Congress conferred on itself, through House Resolution 108, the authority to abrogate unilaterally any treaty or agreement entered into between the United States and Indian nations – a travesty of established principles of international law. The same 83rd Congress also passed Public Law 280 directing five states (California, Minnesota, Nebraska, Oregon and Wisconsin) to assume civil and criminal jurisdiction within Indian nations (except Menominee, Red Lake Chippewa and Warm Springs) and authorizing other states to do so unilaterally through their legislatures.

In 1968 the U.S. Indian Civil Rights Act arbitrarily defined for Indian nations the rights of their citizens. The recent (1978) Oliphant Decision decided that Indian nations do not have jurisdiction over non-Indians commiting certain criminal acts within their boundaries. This decision has been based on the very racist assumption (historical and legal) that legal interpretation of treaties should support the assumed position of those who drafted the treaty (non-Indians). These continuing acts of racism have led to unrest and conflict within Indian tribes and between Indian and non-Indian people epitomized by Wounded Knee, 1973 and its repressive aftermath and current anti-Indian movements among non-Indian populations near and within the boundaries of Indian nations.

Such immoral and unjust acts have had an expected diminishing effect upon the land base of Indian nations and upon the natural resources that are potential hope for them. These acts also reveal the economic motives of not only the U.S. and state government, but private interests, individual and corporate, which have urged those governments into immoral acts of greed. The United States has not only built itself as a nation upon the lives and resources of Indian nations, but also it continues its immoral and often illegal attacks upon the economic base of Indian people through continued efforts to destroy the legal and human rights of Indian nations and communities.

The attacks upon Indian nations and cultures and the rapecious exploitation of Indian resources by non-Indian interests is based upon and supported by a legal system which is itself chauvinist. The federal law respecting Indian nations and Indian resources historically has been and, shockingly, continues to be chauvinistic. The federal government respecting Indian nations and Indian resources historically has been and shockingly, continues to be discriminatory against Indian people. For example, federal law still permits the U.S. to take Indian land and other resources without due process and without compensation. This law, which applies only to Indians, is being utilized continually to deprive Indian nations of their remaining lands and resources.

Indian Communities: The concept of an Indian community has been synonymous with the Indian tribe or nation in the past. Today, the Indian nation and land base is still a major focus of community for Indian people, but not the only focus. A large portion of Indian people have been forced off national land bases into urban and other off-reservation communities. This development of Indian communities outside the tribe has happened due to several causes. Some Indian people have left their tribes because of the oppressive economic and social conditions which characterize many reservations today. Many leave as the unknowing victims of the systematic and overt attempts by the

NCCC INDIAN AFFAIRS

government to assimilate Indian people into "the mainstream of American society." These attempts have taken the form of Bureau Indian Affairs boarding schools, which have often forced their Indian students away from their families and their tribes and subjected them to an educational system unrelated to the cultures of their own people. Relocation programs have enticed Indian individuals into urban areas looking for work and "a better life" rather than attempting to build the economy of tribes. Through House Resolution 108, Congress attempted to terminate what little services some tribes received, forcing families off their land base in order to survive economically. All of these political, social and economic pressures have created "off-reservation" communities of Indian people. These communities are characterized by having at least two foci for their cultural, social and political lives. Tribal members still focus on their own tribe for identity, social definition and values as well as for spiritual perspective. At the same time the Indian community which has grown up in a particular setting outside a specific Indian nation is usually characterized by being a mixture of many different Indian cultures. A second necessary focus for members of this community is to seek survival individually, or as families, that are now part of a "minority" within the dominant society.

Some Indian communities must face problems of economic survival since they are cut off from any services of the U.S. Government to their various tribes, because the U.S. chooses to ignore its responsibility to "off reservation" Indian population. Such an immoral historical process has created relatively new Indian ghettos in many major cities of the U.S. Indian people in this circumstance struggle against isolation from the nations of which they are politically part and seek to nurture a new sense of community in which different tribal peoples share common values and common struggles for legal and human rights as Indian people.

AFFIRMATIONS AND DECLARATIONS

(1) A primary objective of the democracy for which the United States stands must be the support of Native American nations and peoples to achieve full human rights as established by their tribal traditions and as protected by their national sovereignty. The National Council of the Churches of Christ recognizes a trust relationship between Indian nations (within the boundaries of the United States) and the U.S. Government. The NCCC recognizes such a trust relationship to dictate a legal, as well as moral, obligation to support the full legal and human rights of Native Americans as individuals within their nations and the world. Such support for the human rights of Indian people includes the right to self government and the right to lead economically full lives based on adequate employment, housing, health care, and education, whether that be as tribal nations or as economically viable communities within the mainstream of American life. The trust relationship implies a commitment to support Indian tribes in their efforts to develop and re-develop their full potential as nations and to protect these developing nations against the encroachment of federal agencies, states or municipalities of the United States.

(2) The National Council of the Churches of Christ will faithfully act on its God-given stewardship responsibility made clear in the Christian ethic of love and justice to provide leadership to the church community in an attempt to develop liberating policies and programs to counteract the results of its past activity. The American churches have participated in and collaborated with oppressive educational politics of acculturation and assimilation of Indian people. Efforts must be made for the support of the development and implementation of strategies to meet the educational needs as developing nations as well as their own efforts to undergird their traditional values, customs and lifestyles.

Furthermore the NCCC commits itself to support Indian efforts to maintain the integrity of their spirituality, their nations, their culture and their families.

(3) Adequate health care is the right of all God's children. Despite guarantees by treaty that the U.S. Government will insure adequate food supplies and adequate health care, many Indian people on and off federal reservations as well as a large number of Indian people not protected under such guarantees suffer from malnutrition and inadequate health care. The American churches have vastly inadequate mechanisms and methods for meeting domestic hunger needs and their root causes (especially those of Indian people) in relation to their much greater commitment to hunger relief worldwide. The National Council of the Churches of Christ will therefore begin to support Indian tribes in their efforts to claim adequate health care as well as provide leadership in insuring support for adequate food and health care through their own internal potential.

(4) The American churches should recognize their sinful complicity, historically, in the destruction of Indian tribal economies and their role (e.g. through investment) in the continued corporate attack upon Indian peoples' natural and human resources and economic bases. The American churches must support Indian tribal and community efforts to develop economic resources in a self-determining way that conflicts with their traditions as little as possible. They can do this through support of Indian peoples' efforts for program resources with the federal government, private resources as well as agencies, corporations and programs within the American churches.

(5) The National Council of the Churches of Christ, understanding the economic and political history of Native Americans in the last four hundred years, commits itself to the support of Indian communities and individuals struggling for their human rights outside the context of their tribal nation. The NCCC affirms the rights of all Native American people to services guaranteed by treaty as well as those services and programs available to all people in the U.S.

(6) The National Council of the Churches of Christ commits itself to support Indian nations, treatied or untreatied, in their effort to maintain their sovereignty as nations. As a part of the Christian church in the U.S., the NCCC urges the United States Government to recognize and respect the sovereignty of these Indian nations as established by law and any lands, jurisdiction and government properly claimed by such nations. The NCCC commits itself to the eradication of all invidious discrimination and racism in the law affecting Indian peoples. The NCCC urges the United States to insure additional lands and resources beyond those "protected" by treaty to Indian nations so that full economic development of such nations is assured.

(7) For too long, the American Indians have not been permitted their rightful place in the national or world community. The American people and the United States have interacted with Indian people as though they are indigenous foreigners – a people indigenous to a land, but foreigners in a country that has grown up around their own cultures, their own nations. Such a relationship is no longer acceptable. The National Council of the Churches of Christ affirms the concept of full participation for Native Americans in their respective nations, the United States and the world.

SUMMARY

The National Council of the Churches of Christ recognizes that Indian peoples must have the freedom to seek full lives – spiritually, culturally, economically and politically – as individuals, as communities and as nations. The Christian Church has a particular and theological perspective with regards to the liberation and fulfillment of Indian and non-Indian people alike as concerns these issues. The National Council of the Churches of Christ seeks to achieve mutuality of understanding and growth towards maturity in its mission to Indian people. The NCCC commits itself to seeking the above stated goals always in cooperation and consultation with Indian people so that each spiritual heritage, each political reality and each cultural uniqueness may communicate and share of its richness for the common good of all peoples. Christian churches work with the Almighty as the Kingdom of God is realized through justice and love always understanding that God is revealed to other peoples and cultures in many and diverse ways.

(Note: This statement supersedes the previous NCCC policy statement, "Indian Affairs," adopted by the General Board, March 3, 1955.)

National Council of the Churches of Christ in the U.S.A.
475 Riverside Drive
New York, NY 10027

NATIONAL INDIAN YOUTH COUNCIL, INC.,
Albuquerque, N. Mex., March 24, 1979.

JOSEPH A. CALIFANO, JR.,
Secretary, Department Health, Education and Welfare, 200 Independence Avenue, SW., Washington, D.C.

DEAR SECRETARY CALIFANO: Last week I attended a meeting of attorneys from around the country who are working on Indian health issues. Naturally we discussed at length our concern, and the concerns of our clients, over the new HEW/IHS contract health services regulations, 42 C.F.R. §36.21 et seq., (1978). While many of our objections to the regulations cannot be readily resolved, there are two critical matters of interpretation which I want to bring to your attention and which, I believe, can be immediately resolved. Specifically, I seek a clarification of 42 C.F.R. §36.23(b) and (c) and 42 C.F.R. §36.23(f).

The situation in Albuquerque regarding eligible students, transients, and other persons outside the contract health service delivery area (42 C.F.R. §36.23 (b) and (c)) is that when these eligible individuals apply for contract health services, the Albuquerque IHS contacts the applicant's home agency and asks that agency to assume responsibility for the costs of the contract health services rendered or to be rendered. In the vast majority of cases, the applicant's home contract health services delivery area is refusing to accept responsibility for the costs of the contract health services being sought. The Albuquerque contract health service office is also denying that it has any responsibility for those individuals described in 42 C.F.R. §36.23(b) and (c). Thus, while these individuals are clearly eligible to receive contract health services under the regulations, they are being categorically denied those services. It is crucial, therefore, that issue a clarification of 42 C.F.R. §36.23(b) and (c) so that either the applicant's home contract health service delivery area or the contract health service delivery area in which (s)he is currently residing (or passing through) is held responsible for contract health services sought by students, transients and other eligible persons who are outside their contract health service delivery area.

The other situation of concern in the Albuquerque area, which is not being consistently experienced elsewhere is in regards to 42 C.F.R. §36.23(f). First a little background information concerning the Albuquerque IHS is in order. The estimated total population for the Albuquerque Service Unit is 20,878. The IHS facility is only open weekdays from 8:00 A.M. to 4:00 P.M. The services offered by the IHS are minimal and do not include any emergency care nor child delivery. At best the Albuquerque IHS can be described as a first-aid station with beds. Additionally, of the 54 beds available only a little more than half are in use as the entire second floor of this three story facility is closed.

The Albuquerque IHS contract health services office is including as an alternate resource those services which are available as direct care in IHS facilities in Santa Fe and Gallup. The Santa Fe IHS is approximately 60 miles from Albuquerque and Gallup is approximately 140 miles from Albuquerque. So, if, for example, the Gallup IHS provides a medical service on direct care that is not available either in Albuquerque or Santa Fe, an otherwise eligible Albuquerque area resident who requires that service will be denied contract health care regardless of the gravity of his/her medical condition and regardless of his/her ability to travel to Gallup. Despite this rather harsh policy, the Albuquerque IHS is in no way assisting applicants for contract health services to travel the long distances involved. Needless to say the current practice of the Albuquerque IHS does not meet the "available and accessible" requirement for alternate resources pursuant to 42 C.F.R. §36.23(f). Again it is crucial for you to issue a clarification of this regulation so that its present construction by the Albuquerque IHS is curtailed.

Your immediate attention to the matter discussed above would be most appreciated.

Sincerely,

ELLEN LEITZER, *Staff Attorney.*

DNA-PEOPLE'S LEGAL SERVICES, INC.,
Window Rock, Navajo Nation, Ariz., July 23, 1979.

Mr. JIM WEST,
IFCO-Pacific Southwest Region,
Zamora Box 39, Tijeras, N. Mex.

DEAR MR. WEST: Thank you for your inquiry about the Indian Health Service. While the Public Health Service over the past twenty five years has somewhat improved the quality and quantity of health care provided to Native Americans, including our Navajo, Hopi, Apache and Zuni clients, serious problems remain. In our office we see many cases of clear medical malpractice that should not happen in Indian Health Service Hospitals: we know of patients who are crippled for life or who have died as a result of poor quality care at Indian Health Service hospitals. Several areas of the reservations have medical services that are entirely inadequate for the population they serve: for example, one hospital on the Navajo Reservation that says it has an emergency room does not even have the equipment necessary to give a blood transfusion to an accident victim.

The Indian Health Service itself as a whole has provided remarkably unresponsive to the complaints of its patient population. The Service only applies for the money that it thinks it can get from Congress, rather than requesting the money necessary to provide the care that is in fact needed by Native Americans. The Indian Health Service has placed terribly restrictive rules on "contract medical care" payments for treatment provided by non-Indian Health Service doctors and hospitals in emergencies and other situations where the service is unable to provide care; as a result, many Native Americans face ruined credit records and hospital and doctor lawsuits for bills that should legitimately have been paid by the Indian Health Service. We feel that more funding and more attentive congressional oversight could help solve these problems.

I would be happy to answer any additional questions that you might have about these problems.

Sincerely,

PETERSON ZAH, *Director.*

STATEMENT ON NONMEDICAL STERILIZATION OF INDIAN PEOPLE

The Division of Church and Society/National Council of Churches in Christ, Interreligious Foundation for Community Organization and the Joint Strategy Action Committee/Indian Ministries Task Force condemn the policy of nonmedical sterilization in any form.

In a press release of November 23, 1976 Senator James Abourezk (D–SD) stated that "over 3,400 American women were sterilized by the Indian Health Service (IHS) or by other non-Indian hospitals at IHS expense between 1973 and 1976, according to a Government Accounting Office report * * *"

"* * * The report indicates there may not have been informed consent by the sterilization patients as required by law."

The JSAC/Indian Ministries Task Force, IFCO and The Division of Church and Society condemn this gross violation of human rights and call for the U.S. Government to cease this practice immediately.

We call on all people, of good will, especially church people of all faiths, to join with us in the following actions:

1. Call upon the Department of HEW to fully investigate this situation to find persons responsible for such sterilization and the extent to which such a practice has become commonplace within the IHS;

2. To utilize all media potential within the church world to publicize this atrocity;

3. To support any effort to responsibly generate a class action suit against the U.S. government on behalf of Indian patients who have been sterilized nonmedically.

We actively seek the support of church related groups sharing our common goal and total opposition to this form of genocide.

Reverend WEST. To begin my verbal testimony, I would like to quote two sources. The first is the National Council of Churches' policy Statement "Indian Affairs," which reads:

"Adequate health care is the right of all God's children. . . . The National Council of the Churches of Christ will therefore begin to support Indian tribes in their efforts to claim adequate health care."

The second quote is from the Indian Health Improvement Act Declaration of Policy:

"The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing

Indian health services with all resources necessary to effect that policy."

In light of the policy of this Nation and of the National Council of Churches, I would like to quickly highlight five points of the written testimony which I have submitted to the committee on behalf of the National Council of Churches and add two others since hearing the other testimony.

Point 1 of the statement reads: The NCC believes the Federal Government should be providing adequate health services through a comprehensive health delivery system to all Indian people. It further believes that the Department of Health, Education, and Welfare through the Indian Health Service is not fulfilling this commitment at this time.

In this statement I have outlined historically through the Snyder Act, the Transfer Act, and finally the Indian Health Improvement Act the bases for which we make this statement that in fact Indian health care delivery is to be provided to "Indians," "Indian people" and/or "Indians throughout the United States."

In spite of these facts, the Indian Health Service has developed a system of health care delivery which arbitrarily limits its patient population far beyond service eligibility spelled out in legislation regulating this agency. Despite clear legislative guidelines, the IHS is moving closer and closer to eligibility requirements based on the legally ill-defined status of recognition and on an Indian individual's presence within the boundary of his or her recognized tribe.

As an example of this I would point to the letter which is attached to my testimony from Ellen Leitzer on behalf of the National Indian Youth Council to Secretary Califano.

The NCC feels that such arbitrary definitions of eligibility for health services by IHS to Indian people are morally unacceptable in light of the trust relationship between the U.S. Government and Indian people.

Therefore, the first recommendation is that the committee investigate the present state of IHS eligibility standards and their relationship to the legislative mandates under which this agency is supposed to function; and it is further recommended that this committee in its field hearings seek out testimony from Indian people not currently considered eligible under IHS regulations.

Statement No. 2 reads: The National Council of Churches is alarmed at the recently promulgated HEW/Indian Health Service contract care regulations, 42 CFR, part 36. These regulations would appear to be a specific attempt by the Indian Health Service to arbitrarily limit eligibility in contradiction to congressional intention. Through these regulations the Indian Health Service effectively denies most off-reservation Indian people fundamental health benefits for which they have been eligible in the past.

I have listed questions at the end of this statement which I think might be pertinent to be asked by this committee in its field hearings.

It is further recommended that this committee seek out and include testimony from off-reservation populations of Indian people in these same hearings.

Statement No. 3 reads: It is the position of the National Council of Churches that the potential positive effects of the Indian Health

Improvement Act, 94–437, and the Indian Self-Determination and Educational Assistance Act, 93–638, have proven less effective than possible in improving health service delivery to Indian people.

We see this as a result of two factors. I quote to you now from a report by the American Friends Service Committee entitled "Impact of the Federal Budget on Native Americans." They state that the current fiscal year 1980 budget for the Indian Health Service, which is $585.3 million, falls somewhere between 50 and 60 percent of the authorization level of that bill.

The second reason is exemplified by the HEW personnel's lack of ability to develop competence to respond to the Indian nation's efforts to plan for more comprehensive health service delivery.

The Indian Health Improvement Act is well-written in general and is an important step forward in improving Indian health in the future. The legislation does have at least one shortcoming that I would like to mention at this time. That is that it does not allow for training or technical assistance with regard to tribal efforts to develop tribal specific health plans.

Some Indian nations with prior capability for health planning and service delivery and with riders are improving their potential in these areas. Many tribes that have had little capability for health planning have very poor service delivery and are not able to utilize either 94–437 or 93–638 to improve their capability.

It is recommended that increased technical assistance should be made available to tribes by broadening current legislation. Indian nations should ultimately gain complete control by nation and/or collectively over the delivery of Federal health services to their citizens within and without the borders of their nation.

Statement No. 4 reads: Alleged malpractice by Indian Health Service personnel continues to be a significant problem for the Indian population they serve.

In addition, the Division of Church and Society, along with the Interreligious Foundation for Community Organization and the Joint Strategy and Action Committee/Indian Ministries Task Force has taken a clear stand against alleged sterilization abuse of Indian people by the Indian Health Service.

The NCC recommends that the quality as well as the quantity of health service delivery to Indian people by HEW be investigated, specifically including the occurrence of malpractice by direct and contract personnel of the Indian Health Service.

Statement No. 5 reads: As a Cheyenne with a deep belief in the traditional spiritual way of life of my people, and as an ordained minister of the American Baptist Church of the USA with a deep commitment to the ministry of Jesus Christ, and finally as a person who has spent 3 years in the University of New Mexico School of Medicine, I feel I am qualified to suggest that the time is long past due for any health service delivery system by the U.S. Government to Indian people to be sensitive to, supportive of, and coordinated with the beliefs, both tradition and Christian, of the Indian people it serves.

I have personally seen numerous examples of a lack of sensitivity on the part of IHS personnel toward the belief systems of Indian people. This is especially true as regards the traditional spiritual beliefs of Indian people.

Such a lack of sensitivity is not all malicious, but is often a result of inadequate recruiting and orientation on the part of the Indian Health Service.

The National Council of Churches recommends that this committee investigate the extent to which the Indian Health Service has developed a system of health care delivery that is sensitive to the beliefs and mores of Indian people.

The last two comments I would like to make are in support of the comments by Dr. Rhoades concerning this same last issue I have mentioned. In fact, being sensitive to traditional medicine ways of Indian people does not in fact include just the discussion of drugs, but includes a much larger discussion of health delivery.

As an example, when I was in medical school wholistic medicine, as it was called, was something that was being investigated and rigorously pursued by schools of medicine throughout the country. It is my contention that Indian medicine traditionally has treated not only the whole person but the whole family in a way which is much superior to the system by western medicine.

My second comment that I would like to add onto this is to disagree with the Senator concerning the matter of the problem of nuclear waste in his comment to Mr. Powless. It is my contention that in fact whether a health issue is a part of an issue that is affecting the States around Indian people, the whole Nation, or in fact the entire world, this statment applies. I am reading now from the Indian Health Care Improvement Act findings, section 2(a):

> Federal health services to maintain and improve the health of the Indians are constant with and required by the Federal Government's historical and unique legal relationship with and resulting responsibility to American Indian people.

It would be my contention that no matter where else the health issue might impact, if in fact it impacts the lives of American Indian people it is an issue for the Indian Health Service and the Health, Education, and Welfare Department.

On behalf of the National Council of Churches, I again thank this committee for the opportunity to share with you. I wish you well in your field hearings. I will be glad to answer any questions I can at the appropriate time.

Mr. REEVES. Senator, would you like to deal with questions that arise——

Senator MELCHER. No. Let's have the panel proceed and then we will get to the questions later.

Mr. REEVES. All right.

David Adair will speak next.

STATEMENT OF DAVID R. ADAIR, PROGRAM DIRECTOR, OKLAHOMA INDIAN MISSIONARIES, UNITED METHODIST CHURCH

Rev. ADAIR. Again I want to thank you for the opportunity to be here. I will not disagree with the Senator. The last time my family was here and we did, we moved from North Carolina to Oklahoma. [Laughter.]

This statement is a corporate statement of 30 people, mostly in the public health service from across the Nation. I had my own hearing.

Therefore, I may not even agree with some of these things. However, because it is a corporate statement, I would not feel true to my commitment to them if I did not make it. I would like to read it.

In the society of this Nation, formed by immigrant peoples, often referred to as a capitalistic system, the delivery of health care systems is directly tied to the economic base in which the individuals find themselves.

Foreseeing this, our grandfathers, finding themselves forced to cede the economic bases of the nations, sought to insure the health, education, and welfare of Indian people by requiring guarantees from the Government of the United States to deliver such systems. No past, present, or future governmental policy or program can replace or negate this guarantee. Any development of a national health insurance program cannot affect the unique responsibility of the United States of providing health care specifically for Native Americans. A system of Indian health service must remain intact and effective.

Presently there are needed changes in the Indian health service system to make the program adequate and equitable. The present service, though inadequate, is underfunded. There must be immediate funding of health service programs at a rate of 100 percent of the budgeted needs.

Further, the program must be developed to deliver to Indian people comprehensive and adequate health care. Health service must cease to be developed only on a crisis basis, and include preventive medicine and educational opportunities.

The delivery of services must be related to the census and the location of the people, and that census must be accurate. The presence of alternate governmental health care delivery systems must not affect the eligibility of Indian people to take part in the program created as partial payment for lost resources. Urban people must be allowed full participation in the Indian Health Service programs.

The Indian health care system must develop a wholistic approach. Professional personnel must be able to understand the uniqueness of the Indian people and must treat not the disease but the person.

We must have immediate programs of recruitment of Indian people for professional health care careers. We must increase and intensify the involvement of health workers in the Indian community, and not only at the health care facility. There are needs to increase "community health representatives;" "women, infants, children," and "maternal child health" programs. All programs must seek to affirm the traditional concerns and mores of the people.

Delivery systems must be adapted to the special needs of the community served. Veterans' programs must be developed in areas not served by veterans' facilities. The special needs of women must be addressed and delivery systems designed to go to the community. Special cultural needs must be understood by the health care professional, and such concerns must become a part of the health care itself.

There must be standards for eligibility compatible with the cultural concerns and needs of the Indian people. There needs to be an immediate increase in the number of health care facilities. There needs to be construction of facilities for aging Native Americans which will allow them the dignity of being an elder of our people. The ratio of beds and personnel must be equitable with that of the general public.

In all administrative concerns the opinions and participation of the Indian community must be emphasized. The community must have input into the personnel program. There is a need to develop official "patient advocacy" programs. The rights of our people, while confined, must be affirmed. These rights must include traditional patterns and values. Within the National Government there must be Native American consumer advocacy.

In conclusion, we call society to task, that its promise of health for our people, in exchange for the vast wealth that was ceded, remains fulfilled. In the name of the Creator and judge of all men, and in the cause of justice, we ask that this debt be honored.

Mr. REEVES. Thank you, David.

Gene Crawford, you may proceed.

STATEMENT OF EUGENE CRAWFORD, EXECUTIVE DIRECTOR, NATIONAL INDIAN LUTHERAN BOARD

Mr. CRAWFORD. Good morning, Senator. Like everyone else, I am appreciative of the opportunity to appear before this committee, what there is of it.

You might be interested that I thought this was important, although I had reservations at Glacier National Park last night but, God willing and Frontier Airlines on time, I will be there tomorrow night.

I think everything has been said that should be said. I would like to emphasize, like Dr. Rhoades, being a member of the Sisseton Wahpeton Sioux tribe in South Dakota, I have many relatives who are dependent on Indian public health for their physical well-being. Unlike Dr. Rhoades, I am not willing to accept the present service of Indian public health that my family, my relatives, my people are receiving. I think it is not adequate.

In my position with the Lutheran Council, U.S.A., my position is to provide funds from time to time and an advocacy for Indian people. What I find at the reservation level is that there is not enough money for drugs, there is not enough money for doctors, and there is not enough money for nurses. Somehow the Indian health dollar does not get down to our people. It is used up on the levels of bureaucracy as it comes down—at Rockville to the area offices and on down.

I would hope that the committee would look at that, where there would be more direct services to our Indian people on the reservation.

There is one thing I would like to briefly mention. One component of the Indian health program is the CHR's, Community Health Representatives, on the medical team that Dr. Rhoades mentioned. These people probably are the lowest people on the unit team; yet they have a direct contact day in and day out with their clients around the reservation. Their pay is very substandard. Their allowance for mileage is not adequate. In fact, our organization does supplement some CHR programs with funds to give them more mileage to visit their clients, to get them to the doctors, and so on.

One of the things that I have noticed in working with some of the CHR programs on the various Indian reservations is the treatment or the lack of treatment and lack of concern with regard to diabetes. At one time in my life I was diagnosed as a near diabetic. I became very concerned, which everybody would. I looked around and found out there was a clinic in Seattle, Wash., the Virginia Mason Clinic for Diabetes. I attended that clinic for a week.

With that in my background as I go around now to the CHR workshops on diabetes and so on, those programs and evidently the training of those people to present these programs are not complete. I would suggest that Indian public health look at some of the successful programs that we have in this country in the dominant society's medical world—the Stanford Clinic and the Virginia Mason Clinic for Diabetes and so on. Those methods of teaching and training should be incorporated so that the health team, when it does go out on the reservation, can actually work and help to prolong the life expectancy of Indians for whom they are responsible.

In closing, I would like to make one suggestion. When you have your meeting in the Southwest, have it at Acoma Pueblo. It is about 40 miles outside of Albuquerque, N. Mex.

They have a brandnew hospital out there that is sitting empty. I visited that hospital a year ago. In questioning the administrator as to why there were no people in the hospital, he told me they had not provided for housing for staff.

One of the problems that they are going to have if they build houses for doctors and supporting staff for that hospital is that it is going to diminish the already inadequate water supply that Pueblo has.

By the way, that hospital is using solar energy. They have within the hospital one kiva for the traditional medicine men to practice in.

That hospital is 40 miles from Albuquerque. It would be very easy, very simple, to bus the doctors and the supporting staff back and forth from Albuquerque. I am sure the doctors and their families and the supporting staff would much rather live in Albuquerque, anyway, come on out, work their shift, and go on back.

It seems to me that, from time to time, Indian public health does not look at things in a realistic way.

If the united Indian tribes of this country deported every non-Indian in this country, as the last boatload of white people left the shores of the United States, I imagine a lot of us would be screaming at the last departing boatload for leaving and running out on their trust responsibility to us.

However, we have to realize that Indian public health and the BIA are created and are there to carry out the trust responsibility they have to Indians. That is better than nothing. They certainly are not doing their job but hopefully, the Lord willing, and I know I will not live long enough, maybe someday they will perform in the way they are supposed to perform.

Thank you very much.

Senator **Melcher**. Thank you.

I am going to recess for a couple minutes. It is after 12. I do want to conclude the hearing, but I find it necessary for a short recess. It will not be longer than 5 minutes.

[Recess taken.]

Senator **Melcher**. The committee will resume its hearing.

Mr. **Reeves**. John Melcher will proceed.

STATEMENT OF JOHN MELCHER, S.J., SAINT FRANCIS MISSION, NATIONAL JESUIT OFFICE OF SOCIAL MINISTRIES

Reverend MELCHER. When I was working at the Office of Social Ministries of Saint Francis Mission, I was doing a study of the aspects of health care on the Rosebud Reservation. I would like to talk about four of those aspects this morning. I will only be able to touch on them. They are expanded in a little more detail in my testimony, which I hope has reached you or will soon reach you.

Senator MELCHER. Your prepared statement in its entirety will be made part of the record.

[The material referred to had not been received at the time of going to press.]

Reverend MELCHER. I would like to touch on them because they may be an example of the kind of "for instances" you have been hoping to hear in further preparation for legislation and work on your oversight hearings.

I would like to touch just briefly on aspects of the situation with the hospital itself, the problem of doctor retention, a couple of budgeting problems in the whole health care scene, and finally a word or two about contract health care on that reservation. I would like to touch on those four areas and relate them to Public Law 94–437.

In reference to the IHS hospital at Rosebud, a little over a year ago, there was great fear among the people on the reservation and people on the health care scene, both tribally and at the service unit, that the unit was going to be reduced to an outpatient clinic from its present inpatient hospital. This caused a great stir on the reservation. It was difficult for the people on the reservation to get information from the Aberdeen area office of IHS about what exactly was the status of their hospital. Finally, they went a petition route and raised over 1,500 or 1,700 signatures asking that the status of the hospital be retained.

Part of the problem that apparently IHS was feeling was that they had lost the entire doctor staff during the summer in a mass resignation. Some of the reasons for that have surfaced in other testimony. I will touch on that in a minute. However, this was apparently part of the problem from the viewpoint of IHS.

Nevertheless, the inpatient hospital status was retained through the fall. Meanwhile it had been recognized for quite some time that with the condemnation of one of the wings at the same time last fall because it was deemed a fire trap, the size of the hospital was cut from 40 beds or 38 beds down to 29 beds.

It was realized there was need for a new facility. Therefore, the tribe and the IHS began trying to comply with the bed methodology which had emerged. Finally a criteria of 45 beds was arrived at.

An initial planning grant of $700,000 was agreed on apparently in the House and Senate Conference Committee. That money was allocated, was held up through the winter, and as far as I know, as of today, is still being held up by the GAO, although appropriated by both Houses. They are still waiting for a comprehensive health care needs assessment from the tribe itself. As I mentioned in my testimony, that is being held up by the fact that the tribe still owes around $7,000 to a planning firm for this grant.

Therefore, although the land has been set aside for the hospital and the wells have been dug, even the initial planning funding is still being held up. It is a serious problem for those people.

Also, with reference to title IV, the present facility still has not been able to pass the criteria to receive medicaid and medicare reimbursements. That has been dipping into and seriously deteriorating the funds available to that service unit.

I mentioned the mass resignation of the staff 1 year ago. Since the dwindling of doctors available because of the draft, it has been very difficult to retain doctors at the Rosebud facility. I expect this will prove true at other facilities as well.

Most of the reasons given have been the fact that lab equipment has been inferior or is not present, that doctors are faced with diagnostic situations which are so inferior to what they are used to that they are frustrated professionally, that lab results are often very much delayed, and that housing units have not been significantly improved since many of them were put up 20 years ago and very few have been built. Consequently, housing is very difficult to get. It is sometimes even more difficult to get for Indian staff than it is for white staff.

In light of all these factors, recruitment is very difficult. When doctors do come in and talk to people who are on the staff and hear about the fact that they are operating at one-third, one-half, or two-thirds of what their staff should be and consequently are pulling double and triple shifts as doctors, they are not inclined to walk into that kind of situation. They are not open to being recruited. Therefore, recruitment is a very difficult problem.

Also, doctors who come into that situation right out of medical schools or if they come in from commissioned corps work, if they are career PHS people, it takes a certain amount of time for cultural differences to be learned, to feel comfortable in a situation, to make contacts in the community, and to begin to understand patients who are of another culture. That is just one more frustration that at least initially, for a year in many cases, is added on to what a doctor goes through. Consequently, doctor retention is a significant problem at this facility. That problem would have reference to title II of Public Law 94-437.

Again with reference to title II in terms of budgeting, one of the witnesses this morning—I believe it was Dr. Rhoades—said that the IHS budgeting right now is largely shackled by the historically based budgets which were reduced in 1955 and have only been allowed to increase incrementally from that time. That certainly has had its effect on the Rosebud facility.

Programs that have been begun, such as special surgical units, in the facility and through the service unit have not been allowed sufficient funds to even continue or to grow at the rate at which people would like to take advantage of the services.

I think this is a significant budgetary and bureaucratic concern. The Aberdeen area office of which the Rosebud service unit is a part apparently received a mandate from the IHS office in Washington. Whether that came from Congress or from the IHS, I was not able to determine. However, the mandate was that the Aberdeen area was to cut across the board in the area. They were given a dollar amount and the number of personnel, 80 personnel. It was up to Aberdeen to decide how to do this.

Aberdeen submitted two plans to Washington to accomplish this end. One of them was to reduce three of the service units to the hospitals in the area, two outpatient clinics, and also to eliminate all the health educators in the entire Aberdeen area, all 10 health educators. Rosebud was not included in that plan.

Their other plan was to reduce the Soo San facility, the IHS facility, in Rapid City to an outpatient clinic and again to eliminate health education.

The area I would like to highlight was the unilateral decision across the board in the entire area to eliminate health education which is an online item in the IHS area budgets. It was a unilateral decision, without consultation with the tribes, to eliminate health education.

Seemingly, it is going to be very difficult to deal with the problem Dr. Rhoades highlighted of having people deal with their illnesses at home, treating themselves and their children at home, if they do not have the opportunity for ongoing health education. Yet this is what this particular area office has chosen to do.

Finally, I would like to say a word about contract health care, again with reference to title II of Public Law 94–437. At the present time the Rosebud service area was allocated around $600,000 for contract health care. Due to lack of a surgeon for a great deal of the time in the past fiscal year, due to a lack of an Ob-Gyn man, they have had to contract out a great deal of care. This trend is not unique in this particular year.

As a result, their estimate is that by October 1, the end of this fiscal year, they will have overrun their contract health care by at least $140,000. This is not a situation which they find very pleasing. First of all, most people would rather have the care close to home where the patient can be close to relatives.

Also, whether or not that tab of $140,000 is picked up is totally at the discretion of the area office. There are people on the reservation who are fearful that because of run-ins in the past fiscal year with the area office Aberdeen may not pick up that tab of $140,000-plus for contract health care.

In summary, these are types of issues that certainly are surfacing on the Rosebud Reservation. I do not think that reservation is unique. I think in all your field hearings you will hear similar issues. I hope that witnesses there will be able to be concrete to enable you to bring about the kind of legislative action that will deal with these real concrete health issues that are affecting people.

At this time I would like to offer the services of the National Jesuit Office of Social Ministries and the Catholic Bureau of Indian Missions in any way to your committee in researching either the field hearings or in your work in Washington. Please let us know if we can be of any service in preparation for researching or any way in these important hearings.

Thank you.

Mr. REEVES. Senator, I believe that completes our presentation. I have a couple questions I wanted to ask you, but this is your hearing. Let's proceed that way first.

Senator MELCHER. Well, maybe it is because we are closely related but, John, I find that you present the type of information that I most welcome. We do not want just to talk about the problems. We want to do something about them.

If those hospital funds are being withheld for some reason that we can correct, we surely will.

I had anticipated that I would hear testimony about doctor shortages and physician support shortages. I think that situation exists throughout the country. I suspect we will encounter such issues in our field hearings.

It is apparent, as you stated, John, that a doctor is not going to want to remain in an area where the laboratory facilities, the laboratory backup, and the other medical support systems are not available. Under such circumstances doctors will be encouraged to walk out.

I also read a letter from Legal Services submitted by Jim West, I believe, that this is the kind of data we want to collect and react to. We want to work with the IHS in making note of the shortages and inadequacies of Indian health care.

This problem, I believe, must be properly assessed by the tribes themselves and the Indian community throughout the country. I personally believe that hospital care close to home is very essential. We will try to examine this area during the course of our field hearings if Indian people throughout the country believe it is important. I think we will find it is extremely important.

Gene, did you say that you are a Sisseton Wahpeton Sioux.

Mr. CRAWFORD. Yes.

Senator MELCHER. Is Sisseton Wahpeton Sioux a single tribe?

Mr. CRAWFORD. Yes; it is up in the northeast corner of South Dakota.

Senator MELCHER. Where is the agency?

Mr. CRAWFORD. The agency is at Sisseton.

Senator MELCHER. You do not want your family treated by the Indian Health Service. Is that correct?

Mr. CRAWFORD. I want them treated adequately.

Senator MELCHER. You are wondering whether they will be adequately treated by the Indian Health Service?

Mr. CRAWFORD. It is not adequate from my observations.

Senator MELCHER. That is a point well made.

You made this point although you did not discuss the amount. However, the fact is we are talking about $615 million for fiscal year 1980 for Indian Health Service. That is almost $1,000 per man, woman, and child that the Indian Health Service lists as Indian. They list about 760,000. As I understand it, this amount does not include any funds that might come available to Indian people through medicare or medicaid.

Therefore, you are correct in that it is a large sum of money and one wonders how it is spent. We want to find out how these funds are expended. We will be dealing directly with the Indian Health Service, as we should, asking if they have recommendations as to how to use these funds for the patient in the most expeditious and economical way. When I say economical, I do not mean for medicine to be treated as an area where one tries to economize. That is one of the gross faults in this country—that we try to economize on so many things.

When you try to economize on health, you are not economizing on anything. You are just creating more problems, which creates an additional cost in suffering, loss of life, or very often in actual health care expenditures later on because you avoided doing what you should have done in a timely fashion. Preventive medicine is essential. If it is not available, more people will be uncomfortable, unhealthy, or die. Without adequate preventive medicine, more money is spent in the long run.

Mr. CRAWFORD. Senator, John Melcher mentioned the hospital situation at Rosebud. The Sisseton Reservation has been picked and their money is being held up, too, for the determination of methodology for hospital bed distribution.

The problem with that is when Congress tries to apply a formula for the distribution of hospital beds, they are looking at urban situations. Of course, the reservation is rural, isolated, and very, very unique. You cannot use rules and formulas that are practical for the dominant society. It is simply the opposite.

Senator MELCHER. I certainly agree. We fight that battle continuously. We have a problem where almost any locality in Montana would be classified rural. There are only three areas that would not be classified rural: Great Falls, Billings, and Missoula. The remainder of the State is classified rural.

We have a tremendous problem dealing with what has become a top-heavy bureaucracy in the field of health care throughout the country. Unfortunately, too much authority for making these decisions has been delegated by Congress to the national level. We are learning to regret that situation when we attempt to justify health care needs in terms of the amount of beds and the amount of facilities that should be available in rural areas in a State such as Montana.

I now would like to return to another issue. I cannot understand, Reverend West, your comment in regard to the possible health hazard involved by the presence of nuclear plants. I am going to ask you to elaborate, because, as I understand it, and as I think it will appear on the hearing transcript, you are attempting to make a case that the Federal Government has a special problem with Indians resulting from a nuclear mishap or from the presence of a nuclear plant in an area.

I would assume that the dangers surrounding nuclear development and the apprehensions many of us experience concerning the direction nuclear energy development in this country should be shared by all of us. It is common hazard which we must face. I do not quite understand why you would pick out Indian people as being separate from the rest of the population in this regard.

I do not happen to live anywhere near a nuclear plant when I am at home. I live closest to a nuclear plant when I am here in Washington, D.C.

However, I happen to believe that we ought to have a policy in this country to insure that we have adequate safeguards and, beyond that, that we develop a policy on what we are doing with nuclear waste.

Please tell me why you single out Indian people and why we should be more concerned about Indian people in this regard than we are about all of the people in the country.

Reverend WEST. I would be glad to clarify that. I am not saying that Indian people are inherently any more susceptible to the effects.

Senator MELCHER. I understand that. I am not trying to infer that you did.

Reverend WEST. I am not saying that the concerns of nuclear proliferation or waste disposal accidents should be in any sense thought of by the Government in any special way for Indians. I am saying that because those are a potential for health, whether it be in terms of preventive health concerns as an issue or in terms of dealing with the effects medically of such a thing, the United States has a unique relationship through its responsibility which is clearly spelled out in the Health Improvement Act. It has a unique way of dealing with that.

It will have to respond to all people if there is some kind of huge disaster. For instance, if something should happen with what is going on at Laguna Pueblo, if there should be dust blown from the remains that are left there, it is going to blow across all of New Mexico. It is going to affect all the people in New Mexico, whether they are Indian, Chicano, or whatever.

I am just saying that as it becomes a health issue the Federal Government, through the Snyder Act and through the Health Improvement Act, has a unique, not special or above, legal responsibility to Indian people to respond to that, as they do with any health concern.

Senator **Melcher**. There is a distinction between what we have discussed and the issue of what should be the public policy with regard to nuclear plants. I am now talking about nuclear generating plants, of which there are 72 in this country. That is entirely separate from anything that has been discussed or could be discussed about radioactive tailings.

Reverend **West**. I agree.

Senator **Melcher**. Those radioactive tailings from uranium mining or processing are clearly a responsibility of the U.S. Government. Where such mining or processing has been done on or adjacent to a reservation, the tribe has a remedy through the Department of Energy. If they feel they do not have that remedy, I would be delighted to work with them through the Department of Energy to make sure that the remedy is applied.

However, that is entirely separate from the question of what is public policy in regard to the 72 nuclear plants that are now operating and generating electricity. That is entirely separate.

I think the responsibility for that is clearly a Federal responsibility that applies across the board to everybody in the United States.

Reverend **West**. I certainly would agree.

Senator **Melcher**. I am glad you agree.

If we knew that a health hazard existed, I think our public policy immediately would require us to order the plant shut down. I do not know how we can look to the Indian Health Service to single out Indian people and say, "Well, the health hazard exists and therefore our responsibility is to immediately start treating them," which you have cited as being the case in law, Reverend West. I do not know how we do that.

Reverend **West**. Now I disagree again.

Senator **Melcher**. Tell me how you feel.

Reverend **West**. All I am saying is that if that accident from tailings——

Senator **Melcher**. Oh, you mean in case of an accident?

Mr. **Crawford**. A mining accident.

Reverend **West**. I am talking about if anything should affect the health of Indian people, then there is a unique relationship that defines health service delivery for Indian people. It is defined currently by laws of the Indian Health Service. I am not saying that should be the only thing that the United States does in response to that.

Senator **Melcher**. We will research this, but I am sure there is subsequent law that has made any such accident the immediate responsibility of the United States Government. I do not want to quibble over the extent to which we do not carry out our responsibility under law with the Indian Health Service. It is true the responsibility has not been completely fulfilled.

I had better research it, but I think I can assure you that subsequent law has made nuclear accidents, whether from tailings or from a nuclear plant, the immediate responsibility of the United States Government. If this is not the case, there are many of us who have been working here in Congress this past decade or two who clearly are operating under some gross misapprehensions. We think it is an across the board responsibility of the United States Government.

That is why we have established the Nuclear Regulatory Commission. That is why we have instituted controls by Federal agencies. Frankly, we are grasping for what is our United States policy on the direction of nuclear energy development. I think it is well we do grasp for that and conduct a very careful review at this point in time. Then perhaps the lives of the next generations will not be compromised and endangered.

While we might look to the Indian Health Service to assist in partially meeting the across-the-board responsibility I have referred to, I do not think the responsibility is any less for any American in regard to a nuclear mishap. I see no reason why it should be. We all are entitled to that kind of protection.

While the Indian Health Service might deliver some of the actual care to Indian people, the responsibility of making sure the care is given exists for all Americans. Equal liability exists for all Americans for any damages, losses, or health problems.

Reverend **West**. If such an accident should happen—and hopefully it will not—IHS should play a role in responding to it. I certainly would hope the rest of the people in the country at the present state of things would be a lot better off than the Indian people will in terms of that response coming through the Indian Health Service. However, I hope that will not happen.

I agree with your analysis. I am sure the research your staff will do will probably support your argument.

Senator **Melcher**. Jan, you mentioned food stamps. Although we always are interested in food stamps, that is not subject to the jurisdiction of this committee. However, I am on the committee that does have jurisdiction over the food stamp program, the Agriculture Committee. We do welcome comments along that line. We will be watching for food stamp problems of Indian people when we can, but this committee does not have jurisdiction over the administration of the food stamp program.

Ms. **Harmon**. I am aware that is the case. We were trying to raise the broad range of Indian health concerns. We see nutrition as being one of these problems.

In some instances we may need to go beyond IHS to look at solutions for a good, adequate system of delivery of health care to Indians.

Mr. **Reeves**. We were aware of your other committee assignment when we put this in.

There are a couple other things I would mention in this regard—topics which we mentioned in our list which are not within the purview of this committee.

For example, it appears that national health insurance will get some attention by this Congress. Whether it will move, we do not know. Somewhere in the review of national health insurance the unique health responsibility to Indians has to be looked at carefully. I would hope as you go through your field hearings you would be at least alert to clues as to how that unique relationship is going to be maintained and fulfilled.

Another similar kind of venture might have to do with the application of title XX under the Social Security Act. Speaking for myself, and I should think for most of the people who have joined us in this, health is not only a matter of treating illnesses, but it grows out of the whole social environment and the kinds of communities in which people live. Alcoholism, suicide, and homicide may be seen as symptomatic of social ills.

Therefore, most of us would support the notion that title XX under the Social Security Act might be amended to give Indians more control over their own social environment, or at least to create more favorable social circumstances which will impact on health. It is another instance of the kind of thing that I hope you and your staff will be sensitive to as you move around.

Do you have a comment you wish to make, Reverend LoBiando?

STATEMENT OF GASPER LoBIANDO, S.J., DIRECTOR, NATIONAL OFFICE OF JESUIT SOCIAL MINISTRIES

Reverend LoBiando. Thank you, Senator. I appreciate the opportunity to join in with a few words on behalf of the National Board of Jesuit Social Ministries and the Bureau of Catholic Indian Missions.

I would like to stress the importance of these regional field hearings and the importance of the overall kind of consultation, finding out just how to best spend the money and to see how the money has been spent.

From what I have heard and the little I know, it seems to me that three regional hearings would not be sufficient given the amount of money and the importance of the task you have. Therefore, I would recommend that perhaps it would be possible to increase the number of hearings so that you could have adequate information you need in terms of overall consultation.

The second point I would like to make is that in those regional hearings there will be two aspects which will continually come up, and they have come up this morning. I call one the technical aspect, the delivery of goods in terms of things—of instruments, of machines, and of buildings. The other one would be the organizational, institutional aspect. That means the delivery of human services and the administrative aspect.

Very frequently when you are onsite you pick up much more information with regard to both these aspects than you can through just a general kind of thing.

Thank you.

Mr. Reeves. In this same regard, maybe I am being impertinent for not knowing all the rules, but it has occurred to us that the House of Representatives is not really very well organized to deal with Indian problems. In the review of Indian health they are going to have to express some judgment at some point along the line.

Is it out of order to raise the question of whether there might be some kind of joint venture, either in terms of sponsorship of particular hearings or, if the need is established for additional hearings, some hearings might be conducted under the purview of this committee and some by people on the House side?

I think you share our concern that resources be made to go as far as possible. However, that is really a question which may be out of order for some reason I do not understand.

Senator **Melcher**. The question of holding congressional hearings really is one of who will chair them and when. They are held for the purposes of gathering information and receiving testimony from witnesses that can be helpful in guiding the judgment of individual members of the committee. Therefore, it is a question of which members of the committee are willing to hold hearings.

All the information gained is then available not only to all of the members of the committee and all of the staff members of the committee, but also to any member of the public that would like to read the transcript. More specifically, the hearing record is made available to members of the House who might be interested in it.

I think it is rather difficult to coordinate schedules for members of this committee with members of the corresponding committee in the House, which is still the House Interior Committee, in order to have joint hearings. Sometimes it is done, but it is rare. It is a question of scheduling between two individuals whose schedules probably are very different.

Senator Inouye has indicated his interest in holding a hearing in California at the request of Senator Cranston. Possibly some Members of the House from California may want to participate in that hearing. They always are welcome. We think it is fine if we can accommodate them.

The Navajo Nation has asked Senator DeConcini of this committee whether he would consider holding an IHS oversight hearing in that area sometime this fall. I do not know whether he has made a decision yet, but I expect him to do so.

If that is the case, it may well be that Congressman Udall or other Congressmen from the Southwest will want to participate in that hearing.

Personally I feel that while it is true that the House Interior Committee does not have a separate subcommittee for Indian affairs any longer, that does not diminish the interest of the committee, nor its effectiveness to work with and for Indian people. Chairman Udall makes sure that happens.

Whether or not we can have a greater number of field hearings again will depend upon the willingness of individual members of this committee to take it upon themselves to conduct such hearings.

In addition, there are times when a large number of representatives from tribes are here in Washington at about the same time. Perhaps we could keep that in mind and try to coordinate our activities with them. I think we would find that many tribes would welcome such a hearing in Washington, especially if it would not require a special trip for them. We may think about that for later in the year also. We will see whether that is possible.

Reverend **Adair**. I know you are aware of this, but I would like to point out something for the record. In Oklahoma we have a large Indian population but we do not have a reservation program. In the past some policies put out on Indian health were not appropriate to us. We would be concerned that our people should be represented.

Senator **Melcher**. I think that is very true in Oklahoma. I am aware of that.

Are you a Cherokee by any chance?

Reverend **Adair**. Yes.

Senator **Melcher**. I do not know how to answer that, either. If we concentrate on the Indian Health Service's activities on reservations, I do not know how it helps your tribe very much.

What is the Indian population in Oklahoma? It is quite large, is it not?

Reverend **Adair**. Yes, it is quite large.

Senator **Melcher**. In terms of actual population, it is one of the largest of any of the States, is it not?

Reverend **Adair**. Yes, sir.

Senator **Melcher**. I understand that. Maybe we ought to have a hearing in Oklahoma. Is that correct?

Reverend **Adair**. I would suggest that.

Senator **Melcher**. You have made a good point. I noted it here, because I wanted to ask you to expand on it a little bit.

Reverend Adair, you said, "Special cultural needs must be understood by the health care professional, and such concerns must become a part of the health care itself. There must be standards for eligibility compatible with the cultural needs and needs of the Indian people."

When you say "standards of eligibility," do you mean the standards of eligibility for the health care professional?

Reverend **Adair**. No, sir, for the recipient.

Senator **Melcher**. For the recipient?

Reverend **Adair**. Yes, sir.

Senator **Melcher**. I thought that was what you meant. However, would you enlarge upon that?

Reverend **Adair**. As I said, this was known in several areas. Problems are different in other areas.

Among the five civilized tribes, it historically has been one-fourth blood. No one else was treated. Our tribes exercised their sovereignty recently and reduced it to one-eighth. Of course, that threw such a load on the Health Service that it choked them.

In the western part of the State among the Kiowas a lot of their full-blood Kiowas actually were captives. Therefore, the eligibility is different for that particular area than the eastern part of the State. Some of our full-bloods at statehood refused to enroll. They are not eligible.

Therefore, the concerns of eligibility cause us some concern. I do not know the answers. I know the problems but I do not know the answers.

Senator **Melcher**. Did the Cherokee reduce the blood quantum for eligibility?

Reverend **Adair**. We reduced it from one-fourth to one-eighth.

Senator **Melcher**. Does that make all Cherokees with a one-eighth blood quantum eligible for IHS programs?

Reverend **Adair**. As far as our tribe is concerned.

Senator **Melcher**. It does?

Reverend **Adair**. It glutted the system to such an extent that the system responded and could not operate as efficiently.

Senator **Melcher**. When did you reduce the blood quantum for eligibility?

Reverend **Adair**. Three or four years ago.

Senator **Melcher**. Does that have to be approved by the Bureau of Indian Affairs?

Reverend **Adair**. It was approved by the BIA.

Senator **Melcher**. By the Secretary?

Reverend **Adair**. By the Secretary.

Senator **Melcher**. The Cherokee population could almost double or quadruple, is that right? By how many people did the Cherokee population increase?

Reverend **Adair**. Yes. I could not say for sure.

We are concerned about census, too. It seems if a figure of 60,000 to 100,000 comes out, when we make a payment we pay out to 200,000 people. We do not know how to define an Indian. That has been a problem for years. I imagine it is going to have to come to a final solution.

Senator **Melcher**. Who is the chairman or the president of the Cherokee Nation?

Reverend **Adair**. The chief is Mr. Swimmer?

Senator **Melcher**. Who?

Reverend **Adair**. Mr. Swimmer. Ralph Swimmer from Tahlequah. He owns the bank in our tribe.

Senator **Melcher**. I was on the elevator once with Mr. Keeler. What is his first name?

Reverend **Adair**. He is the one who sold the tribe to Mr. Swimmer. [Laughter.]

Senator **Melcher**. What is his first name?

Reverend **Adair**. His initials are "W. W." I guess it is Bill Keeler.

Senator **Melcher**. I was on the elevator once with him in the Department of Interior Building. We were going up to the Secretary's level. We stopped on another floor and somebody got on. Mr. Keeler said to the lady who got on, "My name is Bill Keeler. I am the chief of the Cherokee Nation. You look pretty enough to be a Cherokee. Would you vote for me in case you are a Cherokee?" [Laughter.]

She was a Cherokee. She said, "I always have voted for you, Mr. Keeler."

I never saw such adept politicicking in my life. [Laughter.]

Reverend **Adair**. You could learn something from us. [Laughter.]

Senator **Melcher**. Thank you all very much. Your comments are very well put and very helpful to us.

Our last witness, Dr. W. M. Decker, will discuss a different area, perhaps a new area, about what we could be doing with regard to Indian health. Dr. Decker is testifying on behalf of the Association of American Veterinary Medical Colleges.

STATEMENT OF W. M. DECKER, D.V.M., WASHINGTON REPRESENTATIVE, ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES

Dr. **Decker**. Thank you, Mr. Chairman.

I will leave my prepared statement with you for the record, if you choose to use it in that way.

Senator MELCHER. It will be made part of the record in its entirety.
[Material follows:]

STATEMENT OF W. M. DECKER, D.V.M., FOR THE ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES

Mr. Chairman and Members of the Committee: The Association of American Veterinary Medical Colleges appreciates this opportunity to express its concern over the need for veterinary medical services to American Indian communities and reservations and new opportunities which may become available during the next few years.

The Association of American Veterinary Medical Colleges is an organization of 28 colleges of veterinary medicine in the United States and Canada. It also has in its membership the departments of veterinary science in the colleges of agriculture in the United States. It also has over 600 individual members who are on the faculties of the colleges of veterinary medicine and departments of veterinary science. These institutions represent the education resources in veterinary medicine and a significant part of the research capability dealing with animal disease, its relationship to human health and the development of control measures for such diseases.

Many of the communities of concentrated populations of American Indians as well as the Indian reservations have had extremely limited and generally inadequate veterinary services for many years. This is probably due to the fact that there has been an undersupply of veterinarians, and the economics of private practice have not encouraged veterinarians to locate in relatively sparsely populated areas, or in areas in which practice would have potential economic problems in its existence. The Indian communities are then generally underserved as far as veterinary services are concerned.

There have been a few demonstration projects in the mountain states conducted primarily by Colorado State University's College of Veterinary Medicine, in which new graduate veterinarians have been assigned to serve on Indian reservations. I understand those experiences have been a success, both for the people on the reservations and for the young veterinarians involved. The veterinarians provided clinical services for animals on the reservation and, in addition to that, improved the control of infectious diseases, those spread from person to person as well as from animal to person. These were short-term projects, however, with little lasting impact. No permanent arrangements have resulted from them.

It would now appear that we have new opportunities. The Department of Health, Education and Welfare has through its National Health Service Corps offered scholarships to students in medicine, osteopathy, dentistry and nursing since the 1973–74 academic year. The National Health Service Corps is administered by the Bureau of Community Health Services of the Health Services Administration. Scholarship awards are managed by the Bureau of Health Manpower of the Health Resources Administration. A student who receives a scholarship incurs an obligation of service as a commissioned officer or civil service employee of the Public Health Service. This has resulted in bringing into the Public Health Service young health professionals who may be assigned to work in medically underserved communities and in the Indian Health Service. Veterinarians have not been included in this program until this year. For the academic year 1979–80 about 50 scholarships will be awarded to students in veterinary medicine. A few of these will be awarded to senior students, most of them, however, to those in the junior year and below. As a result of this, next year a few young veterinarians will be graduated having an obligation to serve as members of the National Health Service Corps and more will be graduated in subsequent years.

This should create a new opportunity for the Indian Health Service of the Department of Health, Education and Welfare to assign veterinarians in underserved Indian communities and reservations. Doing so will serve two important purposes. It will add new dimensions to the health teams and will improve the economics of livestock production on the reservations.

Most people have only a limited opportunity to understand what the veterinary medical profession is. Most know a veterinarian and assume that all veterinarians are in the same type of professional activity. People who live in urban areas think of veterinarians as individuals who treat the diseases and injuries of companion animals such as dogs and cats. Those in agricultural communities have an image of the veterinarian as one who cares for the health problems of food and fiber animals. To others the veterinarian provides health care for horses. But beyond these there are a great many activities of veterinarians which are relatively unknown. Many veterinarians are involved in government programs of disease control and prevention and biomedical research. These programs include the control of certain animal diseases as well as the control of many diseases of human health significance. Veterinarians have for years worked in state and local health agencies as well as the federal government where they have been responsible for the safety and wholesomeness of food, particularly foods of animal origin. They have been concerned with the control of diseases which could be transmitted from animals to man, such as brucellosis and tuberculosis. They have been involved in the detection and control of health hazards in the environment and the workplace. I mention this to emphasize that veterinarians could add significantly to the current range of health services which are provided on Indian reservations.

Tuskegee Institute has operated a prototype study for the implementation of a comprehensive health maintenance program. That prototype has involved the School of Veterinary Medicine at Tuskegee Institute working along with the university hospital to improve the health and environmental conditions of rural southern Alabama. It is parallel in many respects to the provision of health services to those people living on reservations. We have attached a copy of a recent report of that for your information.

We understand that the Indian Health Service hasn't assigned veterinarians to reservation health teams, probably because they haven't been available, it would appear that the Indian Health Service may have a better opportunity to assign veterinarians beginning next year, and in the years to follow, than has been the case in the past. We think they should be encouraged to make the most effective possible utilization of young veterinarians who will become available soon.

National Health Service Corps

scholarship program

fact sheet

March 19, 1979

SCHOLARSHIP AWARDS FOR THE 1979-80 SCHOOL YEAR
(Authorized by Sections 751-756, Public Health Service Act, as Amended)

Students of the health-related disciplines listed below may obtained applications from the National Health Service Corps (NHSC) Scholarship Program for competitive scholarship awards for the 1979-80 school year. Receipt deadline for applications is June 1. Applicants who are first-year students with provisional or alternate acceptance by a school will have until July 13 to submit copies of their final letter of acceptance. Awards will begin to be announced starting the last week of July. First stipend payments, retroactive to July, are expected to be mailed at the end of September for most awardees.

Over 9,000 students of medicine, osteopathy, dentistry, nursing, and other health-related disciplines needed by the National Health Service Corps, have participated in these support-for-service scholarships since their inception in the 1973-74 school year. For each year of support, participants incur one-year commitments to the clinical practice of their health professions in federally designated health manpower shortage areas of the United States. This announcement describes the Scholarship Program for all disciplines for which competitive awards will be available for the 1979-80 school year.

PARTICIPATING DISCIPLINES & AWARDS AVAILABLE

Awards for students of the following five health-related disciplines will be available for competition, with fifty percent of the awards reserved for applicants entering their first year of school, 35 percent for those entering their second year, and 15 percent for entering third year students.

Medicine/Osteopathy- about 1,100 awards for students in full-time M.D. or D.O. courses at U.S. schools accredited by the Liaison Committee on Medical Education or by the American Osteopathic Assocation.

Dentistry - about 50 awards for students in full-time D.D.S. or D.M.D. courses at U.S. schools accredited by the Commission on Accreditation of Dental and Dental Auxiliary Education Programs.

Podiatry - about 100 awards for students in full-time courses for the Doctor of Podiatric Medicine (D.P.M.) degree at U.S. schools of podiatric medicine accredited by the Council on Podiatric Education.

Veterinary Medicine - about 50 awards for students in full-time courses for the Doctor of Veterinary Medicine degree (D.V.M. or V.M.D.) at U.S. schools of veterinary medicine accredited by the Council on Veterinary Medical Education.

Awards for students of the following health-related disciplines will also be included in the competition for Scholarship awards for the 1979-80 school year, with awards distributed as noted:

Optometry and Pharmacy - about 6 awards each will be available for the 1979-80 school year to students of these two health-related disciplines. Only students who received awards from a school of optometry or pharmacy under the Federal program of Scholarships for Health Professions Students of Exceptional Financial Need may compete for these awards.

Baccalaureate Nursing - 80 awards: 20 for applicants completing full-time baccalaureate degree programs before July 1, 1981; 30 for applicants completing programs between July 1, 1981 and June 30, 1982; and 30 for those completing programs between July 1, 1982 and June 30, 1983. Programs must be accredited by the National League for Nursing.

Master's Degree Nurse Practitioner - 90 awards: 45 available to students completing master's degree programs before July 1, 1980 and 45 for those completing programs between July 1, 1980 and June 30, 1981, in primary care, maternal, pediatric, adult, or family nursing specialties which meet the educational requirements for national nurse practitioner certification. Applicants should be graduates of baccalcureate degree nursing programs accredited by the National League for Nursing.

Master's Degree Nurse-Midwifery - 40 awards: 20 available to students completing master's degree programs before July 1, 1980, and 20 for students completing master's degree programs between July 1, 1980, and June 30, 1981. Programs must be accredited by the American College of Nurse-Midwives. Applicants must be graduates of baccalaureate degree nursing programs accredited by the National League for Nursing.

Master's Degree Community Health Nursing - 60 awards: 30 available for students completing master's degree programs before July 1, 1980, and 30 for those completing master's degree programs between July 1, 1980, and June 30, 1981. Applicants must be enrolled in programs of advanced clinical nursing practice specializing in community health, public health, or family-community health accredited by the National League for Nursing. Applicants must be graduates of baccalaureate degree nursing programs accredited by the National League for Nursing.

Master's Degree Public Health Nutrition - 30 awards: 15 for applicants completing master's degree programs before July 1, 1980, and 15 for those completing their programs between July 1, 1980, and June 30, 1981. Programs must meet the "Guidelines for Master's Degree Programs in Public Health Nutrition" specified in Personnel in Public Health Nutrition, published in 1976 by The American Dietetic Association.

ELIGIBILITY

Students are eligible to apply for awards who are (1) U.S. citizens at the time of application; (2) enrolled or accepted for full-time enrollment for the 1979-80 school year with [illegible] beginning no later than Dec. 31, 1979; (3) eligible at the time of obligated service for Federal appointment under Civil Service or appointment as an officer of the Commissioned Corps of the U.S. Public Health Service, and (4) free of other service obligations which might conflict with starting service with the National Health Service Corps, an activity of the Health Services Administration of the U. S. Public Health Service, immediately after training.

BENEFITS

Cash Payments: For the 1979-80 school year the Program will (a) pay Scholarship recipients 12 monthly stipends of $453 (July through June) for student living expenses, (b) pay annual school tuition and required fees on behalf of the recipient, and (c) pay recipients a lump-sum to cover all other reasonable educational expenses for the year, based upon the average expenses of students reported for the recipients' school and class year.

Not Taxable: Under an exemption authorized by Public Law 95-600, November 6, 1978, both the initial and subsequent Scholarship awards are free of Federal tax liability through 1983 for all participants who enter the Program for the 1979-80 school year and for those who entered earlier.

Renewable Beyond 1979-80: Each year, Scholarship recipients are invited to voluntarily extend their support without having to re-compete. Renewals will be granted until graduation or as many as 4 years, if eligibility continues and appropriated funds are available.

SERVICE OBLIGATION

For each year of scholarship support, applicants agree to serve one year of full-time clinical practice as salaried members of the National Health Service Corps after completion of training.

The minimum service obligation is two years. The NHSC assigns its members to qualified, federally-designated health manpower shortage areas in the United States, its commonwealths, or possessions. Baccalaureate nurses will most probably be assigned by the NHSC to activities of the Indian Health Service. Master's-level disciplines will most probably be assigned by the NHSC to maternal and child health (Improved Pregnancy Outcome) programs in States with high morbidity and mortality rates for mothers and children in County, State or Indian Health Service facilities. Although the service location and practice preferences of Scholarship recipients will be solicited from them by the NHSC prior to the service period, nation-wide shortage priorities require that the NHSC make the final placement decisions.

DEFERMENTS FOR TRAINING AFTER GRADUATION

Deferments of the service obligation are currently granted upon request to students of medicine, osteopathy, and dentistry for periods not to exceed 3 years to complete postdoctoral clinical internships and residencies for medical, osteopathic, and dental Scholarship recipients. Longer periods for residencies in general psychiatry and obstetrics-gynecology will be given if pending legislation becomes law. (Medical and osteopathic recipients must complete at least one year of postdoctoral clinical training to be eligible for employment by the NHSC.) Periods of internship or residency do not count toward satisfying the service obligation incurred under the NHSC Scholarship Program. All other disciplines are expected to begin their service period upon graduation from their degree program.

SELECTION FACTORS

Specialty Plans: (Medicine & Osteopathy) - Based on the specialty needs of the NHSC, preference for selection will be given to medical and osteopathic students who plan one-year clinical internships after graduation or who plan entering a primary care residency: general internal medicine, general pediatrics, family practice, and -- if pending legislation becomes law by July 20 -- general psychiatry and obstetrics-gynecology. (Dentistry) - Preference for selection will be extended to dental students who either plan no training or plan to enter general practice training following graduation. (Podiatric & Veterinary Medicine) - Preference for students of podiatric and veterinary medicine will be given to those entering general practice only and to students of veterinary medicine intending to practice on food and fiber animals only.

Ranking Factors: Selection criteria which determine ranking for competitive awards within a discipline and class year include: (a) work experience (preferably health-related) in areas of health manpower shortage; (b) personal background in areas of health manpower shortage; (c) career goal of primary care practice in health manpower shortage areas after obligated service is completed; and, (d) academic performance of dental, master's and baccalaureate nursing degree applicants only, as evidenced by student copies of academic transcripts and, for dental applicants, Dental Admission Test scores submitted with applications. Weightings of these criteria may vary by discipline.

Applicants compete for awards with others in their own discipline and class year. There are no Scholarship award quotas by State or school. Student financial needs, school tuition rates, or marital status are not considered in making selections.

APPLICATIONS & FURTHER INFORMATION

Application materials may be obtained by writing to the Program, or calling the telephones below, indicating your name, address, and the health discipline you expect to study in 1979-80. Application packets should be mailed directly to requestors starting in late March , with completed applications due by June 1 and earliest awards announced around the last week of July. Incoming first-year students who are alternates for acceptance by a school will have until July 13 to submit copies of letters accepting them for enrollment into a school. Application packets for students of medicine, osteopathy, and dentistry will be available during the application period at their schools' financial aid offices.

For individual counseling, students may call the Scholarship Program's toll-free number during office hours, 8:30 a.m. to 5:00 p.m. Eastern Time, Monday through Friday. After-hours or weekend calls on this number will be recorded for reply the next business day.

NHSC SCHOLARSHIP PROGRAM: 1979-80
CENTER BUILDING, RM. 5-44
3700 EAST-WEST HIGHWAY
HYATTSVILLE, MARYLAND 20782

24-Hour Toll-Free Phone: (800) 638-0824
Calls from Maryland and outside the continental U.S.
may dial collect (301) 436-6453 during office hours.

NHSC EMPLOYMENT

The National Health Service Corps is seeking volunteer primary care physicians, dentists, baccalaureate or master's degree nurses, physician's assistants, and practitioners of other health-related clinical disciplines for salaried Federal employment in health manpower shortage areas throughout the United States. For further information, call the NHSC at Rockville, Maryland, toll-free: (800) 638-6730 weekdays from 7:30 a.m. to 5:30 p.m. EST. Calls from Maryland or outside the continental U.S. may dial (301) 443-3407 -- collect.

* * * * * * * * * * * *

The information in this announcement is subject to change. The *Applicant Information Bulletin* for the 1979-80 school year, to be included with application materials, contains the official description of the Program.

00078

Comparative Approach to Health Maintenance: How Will It Work?

Eugene W. Adams, DVM, PhD

SUMMARY

A prototype for the implementation of a comprehensive health maintenance program is described in which the expertise of veterinary medicine is brought to bear on preventive medicine and on special generic environmental disease factors as they impact on human health. For the sake of organization and the ease of presentation, certain specific activities have been divided into two overlapping categories: environmental health and health education.

The implementation of a comprehensive health care delivery system will become a reality only when the full array of health resources is matched with health needs. It cannot be overemphasized that the delivery of health care services is not exclusively within the purview of any one profession, rather, interdependence and sharing of responsibilities and activities in a team approach are characteristics of the human health system.

Basic considerations that establish the feasibility of the one medicine, comparative approach to health maintenance, and present cogent examples of the rationale and the need for the implementation of this concept have been brought into clear focus.[1]

An attempt will be made to describe the mechanisms by which the skills of a veterinarian are brought to bear on preventive medicine and on special generic environmental disease factors influencing the health of the individual in rural and urban communities.

The veterinarian delivers certain services because, by training and reputation, he is an acknowledged expert. But, in other instances, he provides certain services not because of unique impersonal qualifications, but because of the circumstances relating to the settings in which he typically practices. The veterinarian is one of the few health professionals to visit the farm regularly. As an invited professional, the veterinarian has credibility with the rural family and is in an advantageous position to observe threats to human health and to take appropriate action. In addition, it has been reported that in the urban setting there are over 11,000 veterinarians who provide services to companion animals, have an excess of 58 million human contacts per year, and see more people than animals in a given day.[2] Although other professionals are equally qualified to advise the farm or urban family on changes that may be needed in facilities or practices, as a matter of practical reality, certain problems that impact on human health are unlikely even to be observed. Therefore, even if the veterinarian is not uniquely qualified by training or other criteria, he may be the exclusive, or nearly the exclusive, provider of these services.

The underlying concept of veterinary participation in projects to improve health care connotes a team health care approach. The role of the veterinarian may be stated in terms of efforts directed toward the prevention of disease and dysfunction in people. Disease prevention has been cited as the most important single deterrent to present day spiraling medical costs.[3] The development of referral networks and collaboration on projects to improve access to health care are just two examples of the types of programs that will be improved with the inclusion of veterinary medicine.

For the sake of organization and ease of presentation, the specific activities of a comprehensive health care system to which veterinary medicine brings expertise, may be divided into two overlapping categories: environmental health and health education.

Environmental Health

Awareness of environmental health problems associated with water, food sanitation, waste disposal, and pollution as they affect the health of people is essential to a comprehensive health care system.

An improved environment achieved through community education may well lead to reduced health problems.

Some areas of specific interest that may be cited in rural areas are:

1) The improvement of the water supply system by evaluation and correction of bacterial, pesticidal, and chemical contamination of water supply systems (wells, springs, and pumps).

From the School of Veterinary Medicine, Tuskegee Institute, AL 36088. Dr. Adams is associate dean.

Presented before the Veterinary Public Health Section, 106th Annual American Public Health Association Meeting, Oct 17, 1978, Los Angeles, Calif.

2) The correction of improper waste disposal methods that provide food and shelter for insects, rodents, and certain wildlife species (skunks, rats, raccoons) or that are reservoirs for many zoonotic infections, ie, leptospirosis, rabies, salmonellosis, arthropod-borne encephalitides.

Health Education

Through his presence on the farm and by ministering to the health needs of farm and companion animals, the veterinarian has high credibility, therefore, his comments and advice on medical matters are accepted and followed. Specific contributions in the area of health education may well include:

1) Discussion of the relationship of animal health problems and treatment to human health practices, ie, cancer in animals may promote discussions on the value of a breast examination or Papanicolaou's test.

2) Discussion of local health problems (hypertension, sickle cell anemia) that contribute to the emotional and functional well-being of people.

3) Advise animal owners on local health services available in the community and encourage participation in preventive medicine programs.

4) In urban and rural communities, advise on the necessity of stray animal control and the means for reducing the indiscriminate reproduction of dogs and cats.

5) Alert rural populations to the hazards of agricultural chemicals and accident-producing situations that are responsible for ranking farm workers closely behind mining and construction workers in accident rates.

6) Alert the urban population to various environmental hazards, ie, atmospheric pollution, chemicals, animal control, and improper waste disposal.

7) The veterinarian's role in the care of companion animals could be expanded to emphasize recognition of the motives for pet ownership and also an appreciation of the variety of emotional attachments existing between pets and their owners.

It is important to note that *if* a serious demand for health care service exists, which is not being met by our current delivery system, someone will step in and fill that demand. It is better to have the demand filled by a competent health professional than by an untrained person even though this professional may be functioning in a manner far different from our classic concepts of division of responsibility.

Model

A model for the participation of a veterinary medical component in a multi-county comprehensive rural health care delivery system has been proposed by Tuskegee Institute's School of Veterinary Medicine. This health care delivery system, as designed, would consist of at least three closely interrelated major components: Prevention—primary responsibility of the School of Veterinary Medicine; Diagnosis and Therapy—primary responsibility to the Institute's base hospital and its medical mobile units; and Rehabilitation—with primary responsibility in the Institute's Human Resource Development Center. Only the Diagnosis, Therapy, and Rehabilitation Units are currently operating; however, when the three units become fully operational, they would be so interdependent in social and economic aspects, as well as medical, it would be mandatory that there be constant and total exchange of information among team members.

The base hospital would serve as the central coordinator and record repository. Each team member planning a client visit would be expected to clear with the hospital coordinator to learn whether or not there were any special problems, advice, or tasks to be performed on the premises in question. This means that records would have to be current, immediately retrievable, and have at least two levels of information: that which is confidential and that which would be important for client evaluation. Such a system would provide invaluable information for all team members. For example, knowledge that a herd of swine has leptospirosis could provide the crucial key to the correct diagnosis and treatment of a man with a febrile influenza-like illness.

A major problem with most rural health care delivery systems is that of consumer entry into the system. Inasmuch as the proposed Tuskegee Veterinary Component already provides ambulatory veterinary services to a large segment of the rural population, entry into the system is not envisioned as a problem. The major change would be an increase in the scope of services currently rendered and in the integration of the theoretic aspects of the public health activities, with the practical experiences afforded through several clinical outreach programs.

The School of Veterinary Medicine has demonstrated its capabilities and concern for meeting the animal health needs of the rural community through three clinical outreach programs.

1) The Ambulatory Clinic—This activity provides student exposure to some 1,500 farm families (25% of which are low income) in a radius of 35 miles, which covers six counties. Daily visitations are made to farms to treat sick animals.

2) Participation in Southeast Alabama Self Help Association—The mission of this organization, among other community projects not related to animals, is to establish feeder pig units for low income farmers in a 12-county east Alabama area. The School of Veterinary Medicine has provided the veterinary services for this program since its inception. Faculty and students are currently visiting about 75 farms in connection with this project.

3) The Alabama Cooperative Extension Service (Tuskegee Institute, Auburn, and Alabama Agricultural and Mechanical Universities)—This program takes students and faculty into 13 counties and contacts 1,000 farm families. The major thrust of this program is preventive medicine and promotion of improved sanitation.

These programs afford access to a large segment of the rural population. As a result, the initial contributions will center around an expansion of services offe[illegible] during these routine visits. These visits will be supple-

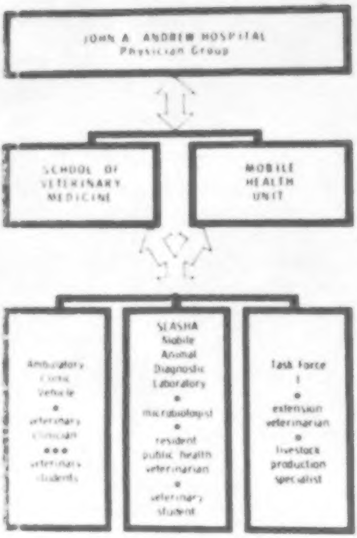

Fig 1—Schematic diagram of the clinical outreach activities and their interface with John A. Andrew Hospital and the mobile units. SEASHA = Southeast Alabama Self Help Association.

implemented later with special calls by request of other team members as they become operational. A schematic diagram of the clinical outreach activities and their interface with John A. Andrew Hospital and the mobile units is depicted in Figure 1.

The essential function of these programs will be to observe problems or to question habits while completing the routine visit and then advise and demonstrate solutions or improvements. An important part of this delivery system will be incorporation of the high risk concept as a resource savings device. The operation will be as follows:

1) The veterinarian's observational powers will be expanded to determine the most prevalent individual health problem in the area.

2) Characteristics that would place a person at high risk for each of the health problems and that readily could be observed or determined will be defined.

3) During routine farm visits, the veterinarian will observe the population for high risk characteristics.

4) When some of these high risk characteristics are observed, the veterinarian will take one of three actions: *(a)* check for further characteristics; *(b)* alert the person to the possibilities and advise action to be taken; or *(c)* refer the person to the mobile unit, other persons, or agencies that can give assistance.

As a specific example, if barefoot children are noticed on a farm that had no septic tank or privy, or where they were not used consistently, the veterinarian would suspect hookworm infection, and could then discuss this possibility with the family, collect fecal samples for flotation, or advise on proper construction of a privy if the family seemed receptive.

The high risk concept demands accurate epidemiologic data that are not fully available at this time. Implementation of this concept would take place as rapidly as information became available and then later be supplemented and refined as further data were developed. The improvement in the collection of epidemiologic data becomes apparent when it is realized that a routine farm visit by a veterinarian is more informal and is much longer in duration than an office call to a physician or a visit to a mobile health unit, thereby greatly facilitating the expansion of his observational powers and the collection of accurate information on needs, attitudes, and risk rates without creating an interview atmosphere with its attendant distortions. Data developed from verbal information would be supplemented by observed findings.

Some important by-products of a delivery system of this type would be an improvement in the retention rate of veterinarians in rural areas through demonstrating a new challenging and satisfying facet to rural practice.

A student training program designed around the previously mentioned activities would provide the veterinary student with an added dimension to the quality and depth of his professional training. A program of this nature also would be vital in properly orienting the veterinary student toward working with other health disciplines to deliver comprehensive health care.

Further, this intensive training in community medicine would broaden the veterinary student's base and would successfully bridge the gap from the academic health sciences to practical application of preventive medicine.

Most importantly, successful operation of this system would have an enormous influence on the delivery of health care, and by eliciting more explicit definition of the roles of team members, would aid in realistically establishing the number of professionals needed in various health fields and specialities throughout the United States.

References

1. Kimmen J, Freeman J, Schnurrenberger PR: Comparative approach to health maintenance: Definition, need, and rationale. *J Am Vet Med Assoc* 175:205-206, 1979.

2. Anderson RK, Fenderson DA, Schuman LM, et al: *A Description of Veterinarians and How They Relate to Human Health*. School of Public Health, University of Minnesota, St Paul. Report to Bureau of Health Manpower, Health Resources Administration (DHEW) Contract #231-76-0202, June 1976.

3. Connelly TH: There is more to health than just paying bills. *Am J Public Health* 64(9):9,7, 1964.

Dr. Decker. Very briefly then I will summarize it. I think I need not make these points very much with you, but perhaps for some who will read the statement it would be useful.

The economics of the utilization of veterinarians in livestock production is pretty well accepted by most people who have any contacts with agriculture or livestock production, but few people really appreciate the interrelationship between the health of animals and the health of people who are in close contact with those animals—the common infectious diseases they share, the common parasites they share, and the common susceptibility to factors in the environment that may be hazardous to animals and to man.

Veterinarians have in very few cases been readily available for service on reservations and in a few cases even in communities close to many reservations. That latter is not uniformly consistent throughout the country, I am certain. However, in many places, as I understand it, veterinary service near communities of Indian populations and on reservations is very, very limited.

There is a new program now in HEW that may have at least some impact on that situation. That was our particular concern in coming before your committee.

The Indian Health Service has not used veterinarians as part of the preventive medical team on reservations and associated with their hospitals in the past. I do not say that to criticize them in any way. I think the priorities that they have to face have been such that they would have been very unlikely to add veterinarians to those who deal with environmental or preventive medical services.

However, now they may have an opportunity at least to try in a few cases to determine what might be done by the addition of veterinarians to those preventive medical teams. I would just direct you to the scholarship program factsheet we have attached to our statement.

The National Health Service Corps has for the years since 1973 been awarding scholarships to students in certain health professions—to students of medicine, osteopathy, nursing, and dentistry. Those students who received a scholarship were obligated to serve in the National Health Service Corps following graduation from medical school or other health professions school. They must serve for 1 year in the commissioned service of the Public Health Service for each year for which they received a scholarship while a student.

One of the requirements of payback in that program is that the young health professional serve in a clinical capacity in his profession. There is a difference to which I would come back in a moment as it applies to veterinary medicine and its traditional activities in public health programs.

Just this year the Department of Health, Education, and Welfare made a decision to extend the scholarship program to some other health professions. They included in that veterinary medicine. They will award in the next couple of weeks, as I understand it, some 50 scholarships for students in veterinary medicine. A few of those, probably about half a dozen, will go to senior students who will become available next year for work in the National Health Service Corps.

We are interested, naturally, in seeing that when those students graduate they go into a productive experience for them and an experience in which they will be productive to society. It concerns us that very little attention has been given to that latter point in the Department up to this time.

A decision was made, one which we did not encourage nor did we oppose it, to extend this program to veterinarians. We saw no indication of an awareness of how to utilize young veterinarians after graduation. Still today we see no real indication that there is an awareness of how to use the new graduates.

However, the Indian Health Service certainly is one place in HEW where these people might be put into very productive work along with the others who deal in preventive medicine, a few physicians in that area, nurses, dieticians, engineers, and sanitarians. The veterinarian could apply his clinical competence to deal with the animals on the reservation, but also add an additional dimension to the current preventive medical team there.

We bring this up at this point because we would encourage you to listen to the opportunities that may be identified for this kind of use of a few young veterinarians over the next several years in this kind of program.

Thank you, Mr. Chairman.

Senator **Melcher**. Has this issue been discussed with the Indian Health Service?

Dr. **Decker**. Yes, it has, but only very, very briefly and superficially at this point. There has been very little discussion within HEW as to how these people will be utilized, whether with Indian Health Service or otherwise. The decision was made in the Bureau of Health manpower and above that to extend the scholarship program to veterinarians and podiatrists but little was learned from the other agencies to determine how they were going to use them.

Senator **Melcher**. Are there any veterinarians on the Indian Health Service staff at any level?

Dr. **Decker**. There are no veterinarians who are out doing work——

Senator **Melcher**. No, I mean anywhere.

Dr. **Decker**. Yes. I think there is only one.

Senator **Melcher**. Only one?

Dr. **Decker**. Dr. Carl Reinhardt has been in the Indian Health Service for a number of years researching with its research activities and headquarters operations.

Senator **Melcher**. That strikes me as rather odd because there are so many public health aspects with which veterinarians could assist the Indian Health Service.

Dr. **Decker**. I would back off my positiveness just a little bit. I am quite certain of what I say because I knew Dr. Reinhardt quite well and have followed him until just the last few years.

As you may know, I was in the Public Health Service for 10 years during the 1960's. At that time I know there were no veterinarians in the Indian Health Service.

Senator **Melcher**. We will see what we can do about that. It truly would be a missing link in delivering an overall health program. After all, I would say almost all aspects of public health work the veterinarians could effectively carry out would be called into play in an adequate Indian Health Service program throughout the country. I cannot think of any area where veterinarians are used in public health work in general where they would not be of the same use in the Indian Health Service.

Dr. **Decker**. I think we have demonstrated very well the ability to prevent disease and improve the status of human health in such a way that it really does reduce the cost of health care and reduces the extent of human suffering.

We look at this opportunity of a few young veterinarians coming out with an obligation to serve in the Public Health Service as just an ideal situation to try on a very modest scale to use a few of them in this kind of situation.

Senator **Melcher**. I am very pleased that it looks like we are going in that direction because it could be most helpful.

We appreciate your testifying here. We made an oversight in not inviting someone to discuss this question earlier. I am glad you were able to respond to our request and supply us with this very important and useful information. It is not the most important area of Indian health by far, but it is important and we should be looking at it as part of the overall success for the Indian Health Service.

Thank you very much.

Dr. **Decker**. Thank you, sir.

Senator **Melcher**. That concludes our witnesses. The committee is adjourned.

[Whereupon, at 1:20 p.m., the committee adjourned.]

OFFICIAL RESOLUTION OF THE NATIONAL URBAN INDIAN COUNCIL, ANNUAL CONVENTION, 1979, ALBUQUERQUE, N. MEX.

RESOLUTION RE I.H.S. CONTRACT SERVICES

Whereas, the intent of Congress with respect to the Snyder Act (425 U.S. 208) is that the BIA (under the supervision of the Secretary) "*shall direct, supervise and expend . . . for the benefit, care, and assistance of the Indians throughout the United States . . .*" for the stated purposes including as the two purposes first described, "general support" and "relief of distress";

Whereas, Congress has appropriated funds for health care of "Indians" as defined in the "Indian Health Care Improvement Act" *irrespective of whether he or she lives on or near a reservation and* in its declaration of policy states its legal and moral obligation to provide the highest possible health status to Indians and to provide existing I.H.S. with all the resources necessary to effect that policy;

Whereas, Congress has authorized and appropriated various funds believing that all Indians mentioned would benefit, and that the phrase "close social and economic ties" contained in 42 C.F.R. Part 36, Subpart C, Contract Health Services—I.H.S. and never defined by the Supreme Court in Morton v. Ruiz, is ambiguous and inappropriate for regulation of health care to Indian people in its practical application by I.H.S.;

Whereas, the local application of regulations in 42 C.F.R. Part 36, Subpart C are discriminatory and inconsistent from state to state, by disallowing urban Indians certain contract services and giving priority of service to reservation Indians which was never the intent of Congress nor mentioned in any legislation: Therefore, be it

Resolved, that the National Urban Indian Council shall formally seek a change in the regulations governing contract health services by the Indian Health Service which will obligate the Indian Health Service to provide contract health services to all persons defined as "Indians" in the Indian Health Care Improvement Act and provide services that are consistent with the stated declaration of policy and intent of that Act.

RESOLUTION NO. 1–79 OF THE GOVERNING BODY OF THE PRESCOTT INDIAN CENTER BOARD (A NONPROFIT CORPORATION INCORPORATED UNDER THE STATE OF ARIZONA CORPORATION COMMISSION) PRESCOTT, ARIZ.

A RESOLUTION IN OPPOSITION TO C.F.R. PART 36 "PROVISION OF CONTRACT HEALTH SERVICES."

Whereas the intent of Congress with respect to their special relationship and duties to Indians as outlined in the Snyder Act (425 U.S. 208), is that, the BIA (under the supervision of the Secretary) "shall direct, supervise, and expend . . . for the benefit, care, and assistance of the *Indians throughout the United States*" for the stated purposes including, as the two purposes first described, "*general support*" and "*relief of distress*";

Whereas Congress has appropriated funds for the health care of "Indians" as defined in the Indian Health Care Improvement Act as, *irrespective of whether he or she lives on or near a reservation* and in its' declaration of policy states its' legal and moral obligation to provide the highest possible health status to Indians and to provide existing Indian Health Service with all resources necessary to effect that policy;

Whereas Congress has appropriated various funds believing that all Indians mentioned would in fact benefit, ROGERS C.B. MORTON V. RUIZ 415 U.S. 199 39 L Ed. 2d 270, 94 S Et. 1055;

Whereas the phrase "Close social and economic ties" contained in 42 C.F.R. Part 36 Subpart C, Contract Health Services—IHS and never defined by the Supreme Court in Morton V. Ruiz is ambiguous and inappropriate for regulation of health care to Indian people;

Whereas the application of regulations in 42 C.F.R. Part 36 Subpart C Contract Health Services by I.H.S. and H.E.W. are in conflict with the intent of Congress and are discriminatory by allowing the States of Alaska, Nevada, Oklahoma and parts of other States to be designated as contract services delivery areas; and

Whereas the Board of Directors of the Prescott Indian Center representing Indian people within the community and State of Arizona are opposed to the attempt by I.H.S. and H.E.W. in its' application of the regulations contained in 42 C.F.R. Part 36 Subpart C, to reject its' moral and financial obligation to the welfare of Indian people; Therefore, be it

Resolved, That the intent of Congress with respect to its' special obligations to the health care of Indian people, be allowed to be carried out in the application of health care regulations by Indian Health Service and the Department of H.E.W.;

Resolved, That in accordance with the intent of Congress with respect to the Indian Health Care Improvement Act, that "Indians" as defined in the Act as *irrespective of whether he or she lives on or near a reservation*, be provided the highest possible health status, and that the existing Indian health services be provided all the resources necessary to effect that policy;

Resolved, That those agencies of the government requesting appropriations before Congress no longer claim to represent service to off-reservation Indians when there is little evidence of such by those agencies;

Resolved, That the phrase "close social and economic ties", and that of "on or near their native reservation" be defined or struck down when used in regulations affecting off-reservation Indians;

Resolved, That the intent of Congress be carried out, and that regulations excluding off-reservation Indians from medical services provided through contracts be changed accordingly; and

Resolved, That the Board of Directors of the Prescott Indian Center instruct the Exectuive Director to bring to bear all possible influence, to correspond with any appropriate individual, agency or committee and to enter this resolution into any official testimony or record that may be appropriate.

CERTIFICATION

I, the undersigned as President of the Prescott Indian Center Board do hereby certify that the Board is composed of Seven (7) members of whom *four* (*4*) were present at a meeting thereof held this *14th* day of March, 1979; and that the foregoing resolution was duly adopted by the affirmative vote of *four* (*4*) members.

DONALD A. DECKER,
President, Prescott Indian Center Board.

Attest:

ROBERT CRUZ,
Director, President Indian Center.